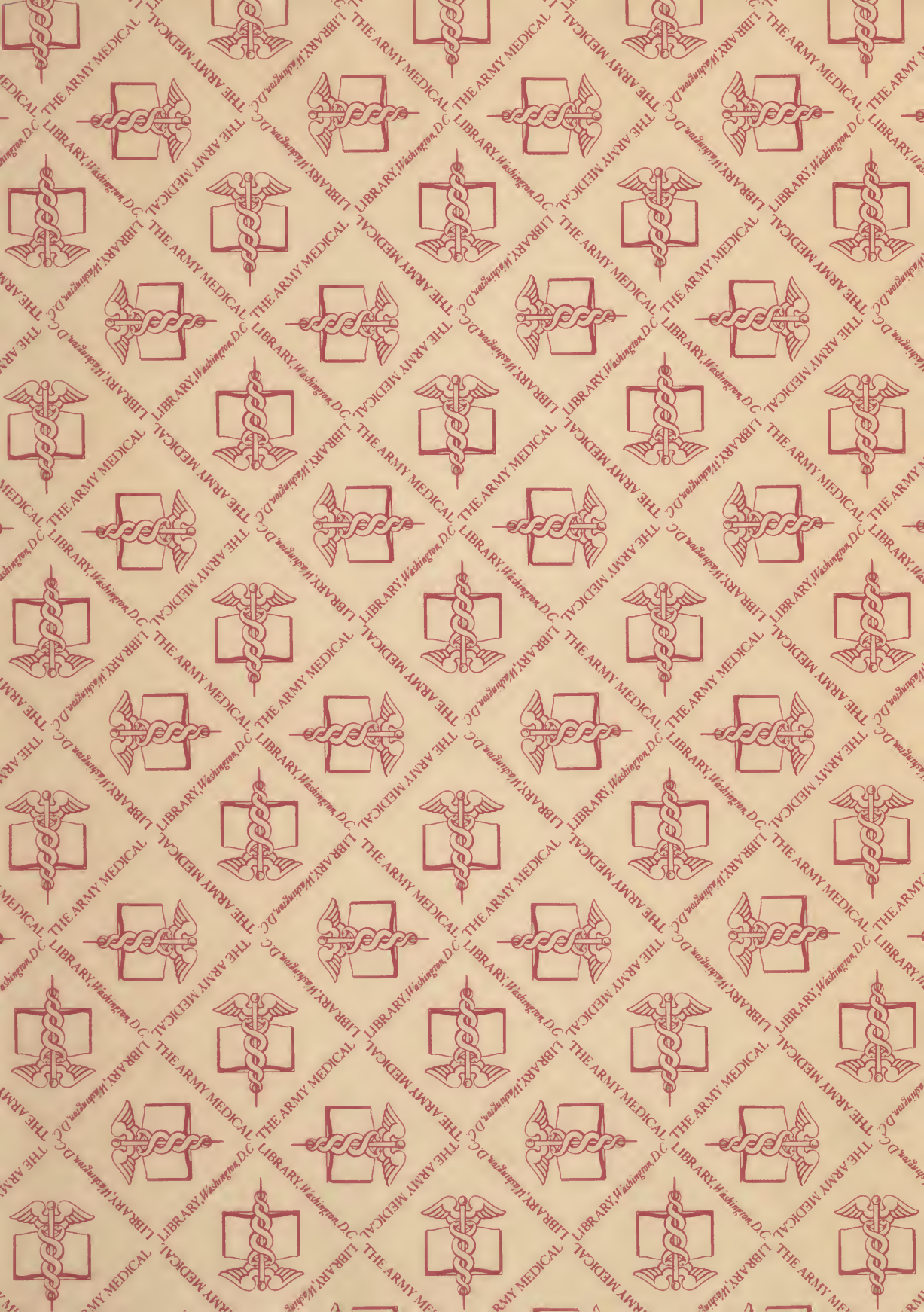
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PROCEEDINGS

OF THE

NEUROPSYCHIATRIC CONFERENCE

of the

SIXTH SERVICE COMMAND

John B. Murphy Memorial Auditorium

AMERICAN COLLEGE OF SURGEONS

50 East Erie Street Chicago, Illinois

16 - 17 NOVEMBER

1945

Major General David McCoach, Jr.

Commanding

Colonel William J. Bleckwenn
Consultant in Neuropsychiatry

Colonel Don G. Hilldrup
Surgeon

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Surgeon

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C O N T E N T S

NEUROPSYCHIATRIC CONFERENCE OF THE SIXTH SERVICE COMMAND

16 and 17 November 1945

Chicago, Illinois

ADDRESS OF WELCOME:

Major General David McCoach, Jr., Commanding, Sixth Service Command: I am very happy, and feel it a great privilege, to welcome all of you to this conference. I am proud that so many of you have seen fit to participate in the discussions we of the Sixth Service Command have arranged for today and tomorrow.

Surely the large attendance at this opening meeting proves that there is something we can accomplish here in the next two days. If we can solve just one problem, or take away enough ideas to help solve just one problem with a little further study, then the conference has been justified.

The exchange of ideas has always been a well-recognized method of solving mutual problems. Here in the Sixth Service Command we have four general hospitals, and at three of them we have specialized treatment centers for neuropsychiatric cases. Bringing together the doctors who have been working at the various centers for an interchange of ideas is the best way I know to provide for such an exchange of ideas. Those representing civilian agencies have been invited, because we know they have helped us, and perhaps now we can help them.

Army medical men can be proud of the part they have played in bringing about the tremendous progress shown in this field of medical science. After the last war, the matter of neuropsychiatric disability was a serious problem. It was a problem that we did not solve too well. There were many men who spent many years in hospitals because we did not know the answers.

Today the situation is far different. It is believed that 98 percent of the men suffering from neuropsychiatric disability as a result of this war already have been or will be returned to civilian life by the army. That record is a marvelous one, and surely we have a right to be proud of it.

Representatives from the Surgeon General's Office in Washington, the Navy Department, and from several of the other service commands are here with us for the conference I know they share with me the pride in the army's achievements, and we are glad they have come to contribute their share to the work of this conference.

I should like to take a moment to pass along a word of praise to the personnel of the Sixth Service Command. Our hospitals have kept step with those throughout the army, and the diligence shown by our doctors and specialists in performance of their duty is to be commended. At our centers for the treatment of neuropsychiatric cases the most modern equipment has been used, and the personnel have contributed many original ideas since incorporated into use. In such a way do we make progress.

But now that the war has ended, and reconversion to peacetime living and to civilian life is the order of the day, it is particularly noteworthy that so many representatives of civilian agencies have joined with the army in a meeting of this type.

I cannot say that this is the first time it has happened, but, if not, I have been assured that this is at least one of the pioneer occasions on which psychiatric, psychological and social agencies have combined in one group to discuss the various phases of the neuropsychiatric problem.

That is very significant. It demonstrates that what the army has accomplished has something of value for civilian agencies. It demonstrates also that each of these groups of civilian agencies has something for each other, as well as for the army. And, most important, it demonstrates that each agency recognizes the others as partners in the fight against neuropsychiatric disability.

Representatives of the various national associations in each of these fields are here to help us and to be helped by us. Nearly all of the medical schools within the service command are represented, and some have sent fortunate medical students to sit in on the conference. If these people in the field of research can be helped in their education, that fact alone would make us proud we had arranged this conference.

You have a fine two-day program ahead of you. I am gratified by the response to our invitations to this conference, and I know the results to be attained here will contribute to even greater progress in this particular field of medical research.

INTRODUCTION:

Colonel Don G. Milldrup, Surgeon, Sixth Service Command: As Service Command Surgeon I am indeed happy to have the privilege of welcoming you to this meeting. It has been the policy of this Service Command to foster medical meetings and the interchange of information

to the greatest extent possible. We have gone all out for post graduate medical meetings in every medical institution, and we have encouraged officers to attend professional meetings wherever possible.

This is third in a series of meetings promulgated by the Sixth Service Command Medical Department during the current summer and fall. In July we had a two-day meeting of the surgical service which was extremely interesting and productive of much information. During the early part of this month members of the medical service met for a one-day session, the second day being spent with the American College of Physicians. The program for this meeting has been prepared by Colonel Bleckwenn with an idea of bringing out for discussion the many intricacies in the handling of neurological and psychiatric cases.

We are happy to see in the audience many of our civilian friends and invite them to enter freely into the discussion and to feel that they are indeed a part of this meeting.

Because of the length of the program it would be inappropriate for me to make any extensive talk, therefore my remarks will be brief. I will now turn the meeting over to Colonel Bleckwenn who will be the permanent chairman.

GREETINGS AND OPENING OF SESSIONS:

Colonel William J. Bleckwenn, Consultant in Neuropsychiatry, Sixth Service Command: May I, too, welcome you most cordially to this conference. On behalf of the men and women in our special field may I express to you, General McCoach and Colonel Hilldrup, our sincere appreciation and gratitude for your continuous wholehearted and generous support to our program in neuropsychiatry. Whatever success we in the Sixth Service Command have had in improving the care of the neuropsychiatrically disabled was mainly due to your keen appreciation and sympathetic understanding of our problem.

Ladies and gentlemen, we are undertaking an ambitious program -- thirty-five papers in two days with selected navy and civilian discussants who represent "Who's Who" in the Middle West. We have in addition to the armed forces invited the American Psychiatric, Illinois Psychiatric, Central Neuropsychiatric, Chicago Neurological, American Psychological, The American Red Cross and all of the state and social agencies of the Chicago area as well as neighboring states. Ten regional universities are represented.

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PSYCHIATRIC REACTIONS OBSERVED ON CORREGIDOR AND BATAAN AND IN JAPANESE CAPTIVITY

By: Lieut. Colonel Stephen C. Sitter, M.C.*

When on 7 December 1941 Hawaii was attacked in a "sneak" raid", feeling among the military and civilian populations of the Philippines was one of amazement and incredulity. Later this was supplanted by an emotion of anger at what was a foul, dastardly deceptive "double play" in international diplomacy.

On the morning of December 8th, the feeling of anger was heightened by the news of the first bombing in the Philippines; namely, Baguio and Camp John Hay, both places being populated principally by civilians and by refugee women and children from Hong Kong, Singapore and Shanghai. As an explanatory note, Camp John Hay was primarily a rest camp for military personnel, but its tactical value was not remotely sufficient to identify itself as a military objective.

Later, in the following few days and weeks, non-military objectives which were bombed -- including Manila which had been declared an open city -- savage brutality displayed by the Jap toward both prisoners of war and non-combatant civilians alike flowered a hatred for the invader in even the most pacific breast. Thus, when the Jap was met on Bataan and Corregidor, the military and civilian alike was emotionally equipped to a type and a degree that is not usually present on battlefields during the incipient stages of a campaign. These prefacing remarks have a bearing on a possible explanation of why many profound abnormal mental reactions were not observed in this theatre of war. It is interesting to speculate whether the emotions of an anger toward, and hatred of, an enemy who was savagely brutal and whose duplicity was despicable was sufficient to neutralize a normal reaction of fear that is present in a proximate area of warfare. Were those same emotions sufficient to neutralize the possible mental conflicts that might be engendered from a soldier's first role as a "killer of his fellow-man"? It was the belief of many of my medical confreres and myself that this actually was the case. There also existed, until about April of 1942, a strong belief that reinforcements would eventually reach us and help drive the invader from the Islands. Messages from the United States had assured and reassured us that "thousands of planes and hundreds of ships would be sent" to the aid of beleaguered Bataan and Corregidor.

For the number of troops involved (about 10,000) the incidence of psychoses on Corregidor was very low. During service on Corregidor from 1 January 1942 until my last visit to that front on 5 April 1942, I had not seen more than a dozen actual psychotic reactions. I was not present on Corregidor after Bataan fell; but in comparing notes with the medical officers

*Vaughan General Hospital, Hines, Illinois.

who remained on Corregidor there were not more than about another dozen psychotic cases during the final month of siege of the Island fortresses of Corregidor, Hughes and Drum. From the day of the first air raid over Corregidor, 29 December 1941, there were always about 8 to 14 cases of superficial to moderate anxieties that would be sent to the Tunnel hospital following each air raid. The majority of these cases were so transient that rest, sedation and the reassurance gained by merely being in the tunnel would be sufficient to make them fit for a return to duty in 4 to 6 days. The subjective symptoms usually were fear, apprehension and a feeling of depression. As they recovered, the patients usually showed irritability - possibly a compensatory attempt to cover a guilt reaction felt because they were in the shelter of the tunnel while their buddies were still "sweating it out" in the Anti aircraft positions. Objectively, the symptoms were usually tenseness, palpitation, dyspnea, depressed affect and occasionally a diarrhea. Mostof the patients were derived from anti-aircraft units, dock worker units and soldiers who manned machine guns above the heavy seacoast defenses. These outfits were subjected to strafing and bombing more than any other personnel on the Island. Very few patients were derived from organizations which had adequate protection during bombing and strafing raids, e.g., heavy seacoast batteries, tunnel installations and headquarters personnel. One case that was admitted to the hospital in January might be of general interest because it was a bit unusual in its course and in its recovery. The patient was a 19-year-old member of an AA Battery who was a very good amateur boxer before the war. He was admitted to the hospital as a litter case, weeping, very tense, markedly depressed, had a clouded sensorium and was retarded in psycho-motor activity. After a few days he was mute, very negativistic, but not hallucinated; he showed a marked startle reaction for 2 or 3 days and then demonstrated a catatonic-like stupor. The latter symptom was present during the day only; at night he would leave his bed and wander to the nearest bed that had an occupant. He would crawl into the bed and if the occupant was asleep the patient would wrap his arms about his bed-fellow's chest or neck and snuggle with this "mother surrogate" - unless the latter awoke soon enough, in which case, "Bobby", our patient, would be led or carried to his own bed. He often wet the bed and also defecated in his bed. After he was in about his fifth or sixth day of mutism and negativism - during which it was necessary to tube feed or spoon feed him, a close friend and battery mate named Johnson was admitted to the same ward with a superficial anxiety. This buddy of Bobby's recovered from his anxiety in about 3 days and then assigned himself to the task of conducting a "one man total push" program (with appropriate apologies to Doctor Myerson). He began his program by spoon feeding Bobby. After a few unsuccessful attempts, Bobby finally permitted this procedure. It was interesting to note that when the patient did take food from a spoon, he would gently bite the spoon in a manner resembling that of an infant who makes his first contact with that eating utensil. Bobby's friend talked to him almost incessantly during the daytime attempting to break down this wall of mutism. After about the twelfth day of mutism, Johnson, the buddy of the patient, approached me with a suggestion

that he be allowed to leave the tunnel and return to Bobby's bombed-out barracks in the hope of retrieving photographs of Bobby's mother or his sweetheart or old pre-war buddies. He believed that these items would be effective in knocking down the wall that the patient built about himself. Johnson attempted to find out from the patient where the approximate location of these articles was. Bobby did not respond to any questioning. Johnson left the tunnel during an hour when no bombing raids were anticipated. On his way to the bombed-out, abandoned barracks, he was strafed; however he was not injured. His quest was unsuccessful. When he returned to the tunnel hospital, he was angry because his mission was unsuccessful because he was strafed, and also because of what he felt was lack of cooperation on Bobby's part. While in this irate mood he began chiding Bobby about his indifference, lack of cooperation and dressed off the tirade with a beautiful array of G.I. vernacular. He ended this harangue with a forcefully presented question and answer proposition: "Your mother and girl certainly would think you're a poor sort of a guy - you don't give a damn whether their pictures are burned, or whether the Japs get them and use them as pin-ups or what happens to them - what in the hell is the matter with you anyhow, Bobby?" For the first time in about 12 days Bobby sat up in bed and spoke: "I guess I'm just a no good, yellow so and so, Johnson." This was followed by an emotional cataclysm of laughing and crying for about an hour, then with the aid of sedation Bobby slept. The next morning he fed himself - ate very little however, and then his improvement was progressive. He retained some lacrimosity for 3 or 4 days, also demonstrated a moderate startle reaction for about two weeks and when he appeared entirely recovered he was transferred to Bataan to work in the Quartermaster area in the rear. The transfer to Bataan followed a disposition procedure that was utilized in profound anxieties or the cases that had recurrent anxiety reactions necessitating repeated hospitalization and, therefore, precluded return to their units on Corregidor. On Bataan better convalescence could be afforded because these patients would then be utilized in rear echelon units, such as Quartermaster, Medics, etc. Following his transfer to Bataan Bobby remained stabilized, and after the capture of the Peninsula by the Japs he remained on Bataan for four days and nights eluding the Japs for those four days, and then successfully made his way to Corregidor at night in a native boat. He withstood the siege of Corregidor and on the surrender of that Fort he was sent to Nichols Field by the Japs to work on an airport. At the latter place, the worst atrocities which were perpetrated by the Japs on the American prisoners of war occured. He witnessed this nightmare for a year and when I next saw him he was en route to Japan, but still intact mentally.

The psychiatric experiences on Bataan were about the same as those on Corregidor, except that beginning about March 1942, cerebral malaria began making itself manifest. The infesting parasite was usually found to be Plasmodium vivax - those infected by P. malariae or estivo-autumnal were, in most cases, rapidly fatal. Later, during captivity this experience with cerebral malaria repeated itself. The symptomatology was quite bizarre in both the

neurological and the psychiatric fields. The sufferers of the disease showed amnesias, fugues, hypochondriacal complaints, schizophrenic-like episodes and affective disorders. Those that survived, were relieved of the mental component of their illness about 3 to 4 days after adequate dosages of quinine were begun - these dosages being about 45 to 60 grains daily for the first 3 or 4 days.

When war came to the Philippines, Major C. J. Katz and I were "custodians" of about 15 constitutional psychopaths in our Neuropsychiatric Section at Sternberg. It was a military necessity to return these people to their units when action began. During the Bataan and Corregidor campaigns, Major Katz and I were able to observe the military efforts of about 8 to 10 of our former "problem children" who were serving with their units. Their military records, in most cases, were very good and in a few cases were exceptional. This observation has been made, I realize, in previous wars and on other fronts in this war. Apparently, in a war the inhibitions placed on their activity are sufficiently removed for these individuals to enjoy themselves. Also, in a war, they find sufficient occasion to relieve themselves of their aggressions. During captivity, the psychopath reverted to his unstable and unpredictable pre-war self.

The observations of psychiatric problems were witnessed by the writer only in one Japanese prison camp; namely, Cabanatuan, where he spent his entire period of captivity. In captivity we again had a low incidence of mental disease. When the population at Cabanatuan was approximately 10,000 to 12,000 our psychotics did not number more than about 40. As the population of the camp decreased, the incidence of mental disease decreased more rapidly than previous rates of incidence would permit us to anticipate. This was in spite of increased hardship and privation. Many reasons have been advanced for this somewhat paradoxical situation. Some of the theories advanced will be presented only because they had a fair number of exponents among the doctors of the camp. All of them present material for many interesting sessions of arm-chair philosophy. The first theory that had rather widespread acceptance was in effect as follows:

During the period of June 1942 to January 1943, most of the captives were so engaged by the pursuit of the primitive instict to live, that problems concerning the psyche were diminished by the individual himself, or at least these problems were never forceful enough to project themselves into the level of consciousness. Those that were not concerned so forcibly with the problem of longevity were among those that died. (Approximately 2500 died between June 1942 and January 1943). The second premise of this same theory was that during the year 1943, when we first had real news from the United States through means of a radio concealed from the Japanese, morale was quite high on an anticipatory basis. It was almost universally felt that the Americans would arrive "any time during the next 3 or 4 months". This feeling was the pragmatic test of the old expression "where ignorance is bliss."

During 1944 there was a slight increase in the incidence of mental disease and here enters the third premise of the theory. Because theyear 1943 did not produce the materilization of the hope that the Yanks would arrive, a few among our group, who were "whistling in the dark", lost hope and mental stability almost simultaneously, thus accounting for the few additional psychotics and psychoneurotics. The remainder of the camp still felt "the Yanks would arrive in the next 3 or 4 months".

Before closing, a word might be included about the psychoses in pellagra. Of several thousand pellagrins, there were only approximately 18 who were known to have suffered psychotic episodes. In that number, if my recollection serves me correctly, all presented symptoms of affective disorders, either hypomanic or depressed, and the latter type was the preponderant one.

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THE DIVISION NEUROPSYCHIATRIST

Major A. J. Boner, MC *

War Department Circular No. 290, dated 9 November, 1943, assigned a division neuropsychiatrist to the office of each division surgeon. The author of the circular manifested commendable insight in providing, "that the division neuropsychiatrist is assigned solely to function as such". The circular also specifically enumerated the functions of the division neuropsychiatrist as follows:

"Advise in all matters pertaining to the mental health of the command.

"Maintain a continuous screening process for the purpose of detecting and promptly eliminating individuals emotionally unfit for military service.

"Be available for the early treatment of normal individuals who suffer from minor correctible maladjustments to army service.

"Assist in a program of preventive psychiatry, especially in its relationship to discipline and morale, thru educational programs and informal discussions with line officers and others who may seek his advice.

"Facilitate reclassification procedures to assure as far as practicable, the proper assignment of personnel.

"Be available as consultant to courts-martial and other boards when his services are indicated.

"Visit division dispensaries and advise in management of psychiatric and psychosomatic problems.

"Supervise the maintenance of proper records of neuropsychiatric conditions within the command to the end that adequate information accompanies each patient evacuated to the rear.

"Keep constantly oriented to the changing psychiatric problems during training, precombat and combat periods, with a view towards developing the mental toughness essential to combat troops.

"Supervise the management of neuropsychiatric casualties during combat."

This was, obviously, an all inclusive program of preventive psychiatry, salvaging of man-power and modern psychiatric treatment.

*Percy Jones Hospital Center
Convalescent Hospital, Fort Custer, Michigan.

The initial step was a "fine-comb" screening of all non-effectives and borderline cases, with their removal from the division. We desired to retain only the perfect fighting soldier in a combat division. War department directives changed and rechanged our direction of effort because of continued reports from the then existing combat areas and the critical levels of the "man-power barrel". With additional experience, we concluded that borderline cases could be used effectively, if properly placed in the division. Reclassification and particularly re-assignment of maladjusted soldiers and officers within the division revealed that an improper assignment was a major factor in precipitating psychoneurotic and psychosomatic manifestations. The incorrigible and the AWOL repeaters, following their release from the stockade, were frequently treated with disdain and unwarranted punitive measures by noncommissioned and even company commanders, whose attitude to these individuals were, "We must make that bastard toe the mark". Clarification of the psychodynamics of stockade inhabitants, removal of the usual "two strikes" against them, an expressed rather than an apparent interest in their problems and the reasons for repeated misdemeanors, resulted in a diminution in the stockade census, the latter usually being considered as an index of division morale.

The initial program of orientation and indoctrination in psychiatric problems met an obvious indifference on the part of both the line and the medical officers. The former clearly resented interference by a medical officer in problems of divisional morale. The latter considered the subject devoid of therapeutic potentialities. To the line officer, especial stress was placed on the early recognition of abnormal behavior tendencies and the interrelationship of the factors of fear, morale and leadership. Every medical officer in the division was sent to a brief but intensive course in the psychopathology and psychodynamics of the combat syndrome. Upon their return, periodic lectures were given in the more recent methods of recognition and treatment of potential non-combat and combat psychiatric cases, with particular emphasis on preventive psychiatry. Field demonstrations, under simulated combat conditions, were given to medical officers and medical personnel, indicating the handling and treatment of the various types of combat psychiatric casualties, first at the aid station and then at the clearing station. In these demonstrations, the variations in symptomatology of the combat syndrome, were dramatized by specially trained personnel, over a loud speaking system to large groups.

It is a universally accepted theoretical fact that a well intergrated personality rarely manifests severe psychiatric pathology. It is also acknowledged that the most stable personality has a "breaking point". These apparently paradoxical concepts as applied to the combat syndrome, are quite tenable in the light of our experiences in combat. Emotional stability, plus a high degree of morale, makes for the perfect combat soldier. The former is an inherent and fixed legacy to the human constitution, and is a more

or less predictable factor in evaluating adjustment to combat conditions. Morale is a vague, inconstant factor, dependent upon acquired information and indoctrination in the course of historical events and during the military training of the soldier. This is understandable in the American soldier in the light of our American ideology. It has been our experience in the division, following the analysis of a selected group of apparently well integrated personalities, according to the most exacting psychiatric standards, that numerous unpredictable factors in the course of military exigencies, were directly responsible in precipitating the so-called "breaking point". These factors were such combat situations as military reverses, rationing of ammunition, insufficient gas for the tanks, poor unit leadership, building up of tension during "holding" military actions, prolonged combat periods with incomplete rest periods. Morale will maintain itself on a high level only in inverse proportion to the incidence of these or similar situations. Obviously, the prevention of the precipitants of decreased morale is a function of command. However, the division neuropsychiatrist, as "adviser in all matters pertaining to the mental health of the command", must be prophetic and emphatic in this particular function.

It was our experience that the greatest single morale factor, and a fundamental one, was the soldier's tenacious identification with his individual fighting group. He knew his buddies intimately. They were dependent on him and he was dependent on them. He would give his life for them, if needs be. The philosophy of group identification served and nurtured his ego. It was a stronger motivating factor than even hatred of the enemy. It transcended all other motivating factors. Actually it was a driving force for group preservation. Morale crumbles when there is a loss of group identification. Military reverses, death and destruction of buddies and equipment, and particularly the absence of proper leadership, transforms the idea of group identification into one of self identification, or self preservation. Under these conditions, the soldier expresses resentment or hostility on a conscious level and in the face of continued combat insults, repressed hostility becomes the forerunner of anxiety or depression, depending upon the inherent personality of the soldier. A comparable situation presents itself in the non-combat soldier. Psychic trauma in the course of his training and preparation for combat, may gradually disintegrate his ideation of group identification. Here the precipitating factors are of an insidious nature, and psychosomatic or psychoneurotic manifestations become obvious. The frequent ineffectiveness of replacements in a combat division may be attributed to the lack of specific group identification.

Psychiatric nomenclature in the divisional area proved to be an important link in therapy. "Combat Exhaustion" and "Combat Fatigue", were dropped immediately following our baptismal of combat fire. Even the innocuous terms of "Exhaustion" and "Fatigue" were, to the psychiatric casualty, connotations of ineffectiveness for further combat. The use of the letter "A" for anxiety, "D" for depression, "H" for hysteria, "F" for fugue and so on, served our purpose more effectively. During the early or acute

stage of the combat syndrome, there is a high threshold of suggestibility and fixations must be avoided. The use of the term "combat syndrome", in this discussion is used only for expediency, realizing that neither this term nor any other, so far presented, clearly describes the total picture, at the divisional level. The term "psychiatric section" is used only for the purposes of this paper. In actual combat, psychiatric casualties were evacuated to the "reserve medical company" of the medical battalion.

The greatest good for permanent cure and return to combat duty is accomplished at the divisional level. Therapy at this level is concerned with the return of the soldier to combat. It was our impression in the division that the evacuation of a psychiatric casualty to the rear of this level, usually resulted in a fifty per cent loss of his chance for recovery for combat duty. It was felt that the division neuropsychiatrist could contribute more efficiently in the treatment and care of psychiatric casualties by establishing a central installation for these casualties by attachment to the medical company, held in reserve. The location of this medical company was usually from 5 to 25 miles behind the combat line. The psychiatric section was a complete unit in itself and sufficiently mobile, so that it could, at a moment's notice, attach itself to another company committed to reserve. However, in the earlier part of the campaign, the psychiatric section found itself stranded as much as 75 miles behind the rear elements of the division. This was due to the fact that there were insufficient ambulances for the transportation of the psychiatric patients receiving treatment and no vehicles to convey the tents and equipment. In fact no Table of Equipment had been provided for the care of psychiatric casualties, prior to combat. Divisional attitude, both medical and command, anticipated comparatively few psychiatric casualties, and it was assumed that all psychiatric casualties were to be treated like any other casualty, by evacuation to the medical companies. The Tables of Equipment of the medical companies were previously completed without taking into consideration the care of large numbers of psychiatric casualties. Ultimately the psychiatric section consisted of an assigned personnel, three ward tents with a capacity of 80 to 100 litters or cots, with a minimum of three blankets to each litter, sufficient mess equipment and food supplies, in case it should be stranded behind the division, a 2-1/2 ton truck to transport tents and equipment, and ambulances from both the division and army area to evacuate the patients.

The psychiatric casualties which were not returned to duty from the aid station were received at the psychiatric section in the medical company for further therapy or evacuation beyond the divisional area. From this vantage point, at the psychiatric section, the division neuropsychiatrist could feel the psychiatric pulse of the division, aided by visits to the various battalion aid stations at regular intervals.

At the aid station, the simple combat exhaustion cases, with or without nervous tension, or obvious fear reaction, on a

conscious level, were permitted to rest for two hours or more and encouraged to return to duty. The battalion medical officer must, necessarily, exhibit rare judgment in differentiating, under combat conditions, fear reactions on a conscious level from fear reactions associated with an anxiety state. To the former, no maudlin sentimentality should be shown. The latter require immediate sedation, consisting from 6 to 12 grains of sodium amytal, prior to evacuation to the reserve medical company. In rare instances of extreme excitement, inhalation of ether was required.

Our concept of the psychopathology and psychodynamics of the combat syndrome warranted the conclusion that immediate sedation, though it produced immobility of the patient to a litter case, was most efficacious in the prevention of the aggravation or fixation of symptoms. In other words, the shorter the duration of conscious knowledge of the symptomatology by the patient, the better the prognosis. Immediate sedation further precludes the possibility of a synthesis of the acute episode, with old, neurotic conflicts which may have been repressed, thus avoiding chronicity. We were fully in accord with the generally accepted concept that therapy, to be successful, must be administrated in the most forward echelon. Therefore, sedation should, necessarily, commence at the level of the battalion aid station. The conditioned reflex of the so-called "startle reaction", could not be satisfactorily deconditioned by subjecting the unsedated casualty to further combat noises, during his evacuation to the psychiatric section. Admittedly, litter cases entailed greater transportation problems. However, this procedure was justifiable in the light of our experiences. As a result of a particularly bitter encounter with the enemy, fourteen soldiers of the same company were evacuated, a distance of fifteen miles, without any sedation. Upon admission to the psychiatric section, one of the soldiers solicited the following information: "Sir, all of us have anxiety state". A stray, unguarded remark by a medical officer, an hour or two of conscious knowledge of their symptomatology and the suggestible influence of the obvious emotional reactions of their comrades aided in the fixation of the acute episode. The iatrogenic factor in psychiatric casualties deserves our serious consideration. This physician generated factor of autosuggestion, based on the medical officer's examination, manner or discussion with patients, has either awakened dormant neurotic determinants or has actually suggested new ones. This was apparent in the division and in our recent contact in a convalescent hospital we have been acutely aware of the contagion of this factor.

Arriving at the reserve medical company, the sedated psychiatric casualty can be aroused sufficiently, if need be, for a change to dry, warm clothing and food intake of hot soup or drinks regardless of the hour of his admission. The following 24 to 36 hours are devoted to continuous sedation with varying amounts of sodium amytal, ranging from 6 to 12 grains. The ingestion of solid food is indicated at any time during this period, provided there is no interference with an effective degree of sedation. Obvious disabling symptoms following sedation

are subjected to narcosynthesis by means of the intravenous injection of a 2-1/2 per cent solution of sodium pentothal in amounts up to ten cubic centimeters. In our hands, under combat conditions, sodium pentothal induced superficial narcosis without any alarming episodes. It was our concept that deep narcosis at this stage of the combat syndrome might re-awaken old dormant conflicts, which would aggravate or complicate the clinical picture.

It was our clinical judgment, not based on experimental proof, that, at divisional level, the symptomatology of the combat syndrome was rather loosely fixed in the upper stratum of the subconscious. With varying degrees of rapidity, the fixations penetrated into the deeper strata and complete fixation occurred. The latter warranted further evacuation to rear medical installations.

The sodium amytal capsule, facetiously referred to as the inevitable "blue 88", was another factor in the fixation of the combat syndrome. To the psychiatric casualty it was a connotation of a combat syndrome with ineffectiveness for further combat duty. When available, capsules of sodium pentothal or other barbiturates were administered with no material decrease in therapeutic efficiency.

A daily dose of 10 units of insulin resulted in gratifying improvement in those cases of complete anorexia associated with negativism, of a catatonic-like type.

Continued improvement at the end of 48 hours was manifested by interest in surroundings, insight, and satisfactory motivation. When conditions permitted, three tents were set up, or three wards in a building during the winter months. One was used for completely sedated cases, one for post sedated cases who manifested satisfactory progress, and the third for the "ready to go back to duty cases". The latter type of cases were assigned to the "refitting company", located at the Administrative Center, the rear element of the division. This company had a line officer as commander. There were facilities for showers, cleaning of laundry, and replacement of lost clothing. Daily lectures were given on the progress of the division in the campaign. A medical officer was present for sick call and reassurance in regard to minor ailments. The atmosphere was deliberately more military than medical.

It should be noted that no mention has been made relative to a careful history. In the division we did not feel that it was our purpose to unearth too much of the past history of the soldier. We did not wish to re-awaken old conflicts either by direct questions or deep and prolonged narcosynthesis. Abreaction for the more recent subconscious conflict serves the function of first aid therapy within the division.

Psychotherapy, or any of the detailed methods of analytical

treatment, is mentioned only in passing. Obviously, they have no place in the therapeutic regimen in a division during combat. However, there is a form of psychotherapy which, unquestionably, produced gratifying therapeutic results, if conscientiously applied, from the divisional level throughout the channels of medical evacuation. It has been referred to as indirect psychotherapy, and includes a kindly attitude and a personal interest in the patient, physical comforts and proper nourishment, Red Cross assistance in the daily distribution of toilet articles, individual soap and towels, cigarettes, Hershey bars and literature, to these patients in the division during combat. An affable salutation by the admitting officer, and a hand-clasp, has frequently been more effective therapy than any other at our command. The material items enumerated are usually attainable, but the abstract phase of indirect psychotherapy has been found wanting. It is a critical indictment that indirect psychotherapy is frequently and unintentionally, omitted in our medical installations. The importance of these simple and obvious measures in the therapy of psychiatric casualties should not be underestimated.

Brig. Gen. William C. Menninger,* aptly refers to statistics in the following words: "Even though we know statistics lie, we invariably place irrational credence in them. The goal for us in the medical department is the efficiency of the unit, not how it looks on paper". The psychiatric casualty statistics of any given division can be evaluated only by a consideration of the many rous variable military situations encountered by that division during a given period. Divisional statistics may be likened to a portion of a picture puzzle. Alone it has no final significance. However, when properly inserted in the total picture, the combined result will prove to be a monumental contribution to military psychiatry.

SUMMARY

1. A well integrated personality, which is a more or less constant factor, combined with a high degree of morale, an inconstant factor, makes for the ideal combat soldier.

2. A few of the many factors which tend toward fixation of symptoms, in the combat syndrome, are enumerated.

3. Immediate sedation, as far forward as possible, beginning at the battalion aid station, is the therapeutic management of choice.

4. The opinions and conclusions set forth in this paper are not to be construed as official or reflecting the views of the medical department of the army, but rather, the impressions of an individual division neuropsychiatrist.

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DISCUSSION of MAJOR A. J. BONER'S PAPER

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Major Boner is to be commended for his clear and comprehensive presentation. The several Division Neuropsychiatrists whom I met in the European Theater have held essentially the same opinions and conclusions as Major Boner has just expressed. Since I have little to add or detract from his paper, I will give you a few words of my own experiences as an Infantry Division Neuropsychiatrist.

Since I entered the service, I have had the good fortune of serving as a neuropsychiatrist in station, regional, and general hospitals, as well as in Neuropsychiatric Consultation Services and as a Division Neuropsychiatrist in the European Theatre. As a Division Neuropsychiatrist as well as in a Neuropsychiatric Consultation Service, the primary function of the neuropsychiatrists is to practice preventive psychiatry rather than to treat and to dispose of cases as generally practiced in Army Hospitals.

I consider the establishment of Neuropsychiatric Consultation Services in the various Training Centers and the assignment of neuropsychiatrists to combat divisions as two of the most outstanding contributions to military psychiatry of this war. In both of these assignments the psychiatrist is offered the greatest challenge and opportunity to help our boys adjust to the service and to keep down the psychiatric casualty rate.

To practice preventive psychiatry successfully, it is mandatory that the utmost support and cooperation of the Commanding General of the unit is obtained. If this is attained better cooperation from the classification, personnel, and plans and training sections is then also procured. Another important function of the Division Neuropsychiatrist is to salvage as many men as is possible and to recommend evacuation for only those who cannot be used in the division. Early or unnecessary evacuation of men to hospitals is fraught with danger. Unless hospital treatment is definitely indicated the soldier often suffers additional psychic trauma when evacuated to hospitals in the rear. There he is placed in close association with other emotionally upset individuals and he invariably finds the morale of the patients considerably lower than that of the men of his original outfit.

Our clearing station was generally situated in school houses, private residences, or in tents from 5 to 15 miles behind the front lines. Here it was not difficult to distinguish those admitted for mental conditions from those admitted for physical injuries. Even those who suffered severe injuries talked freely, joked, and were grateful that they were still alive, whereas the former appeared dejected, depressed, confused, and spoke very little. They seemed to have a guilt feeling for not being able

to take it any further, leaving their buddies behind, and wondering what others will think of them. They generally appeared stunned, blank, or bewildered and their symptoms were of the free floating anxiety type.

Those admitted to the clearing station with mental disturbances were placed in our wards. After taking a brief history and making a cursory examination, the patient was immediately given 6 to 9 grains of sodium amytal with hot drinks. He was then undressed and put to bed. Twelve to fifteen hours later, he was awakened for mealtime. Unless he still remained disturbed he was made to get up, wash, and shave, and one of our men would give him a haircut. We then transferred him to another ward where we had a radio (donated by the American Red Cross), magazines, Stars& Stripes papers, and some large orientation maps on the walls. We saw that he got plenty of nourishment. An attendant was present at all times to see that the conversation the patients carried on was not harmful to their well-being and he did not allow them to sit alone and worry. We encouraged those who had improved to help their buddies keep occupied by playing checkers or leading healthy discussions. I had two trained psychologists and 4 or 5 ward men who were carefully instructed not to be too firm, not too solicitous, but friendly to the soldiers. We posted a daily war bulletin on the wall and I passed on all information I could get in regards to our army positions, who were on our flanks, and how promising the future appeared. I assured them that our casualty list was not nearly as bad as many often surmised when they got excited and panicky.

Intravenous sodium amytal was given to some of the more severe cases. If this failed I gave them faradic non-convulsive shock therapy with intravenous sodium amytal. Very favorable results were obtained with this treatment and I am now preparing a paper of my results with this type of treatment for publication.

I made a practice of not keeping any patient in our unit for more than four days. When we were unable to dispose of our patients within four days an increase of psychosomatic complaints usually became quite common. They found life away from the front lines too comfortable and pleasant. Not infrequently on the third day such remarks as "By the way, 'Doc', what is wrong with my elbow," "Why does my heart pound so fast," or "I get severe headaches often," were made. I would promptly reexamine the soldier and then explain to him how psychosomatic conditions arise and the danger of worry about symptoms when no underlying organic basis could be found. This early reassurance had proved very beneficial in our experience.

We designated all of our cases as C.E. cases (abbreviated for Combat Exhaustion) for want of a better name. I believe that Major Boner's method of using letters to designate different reaction types was an excellent idea. In most Divisions 6 per

cent of all admissions to clearing stations were C.E. cases. In three months of continuous active combat duty in our Division only 4 per cent of all admissions were admitted for this condition. We returned 65 per cent to duty, but this percentage would be higher if we did not evacuate 12 per cent of our admissions for trench feet or other physical conditions found in conjunction with their mental disorder. Only 20 per cent of our patients were sent on to evacuation hospitals for mental conditions alone for further observation and treatment. Only 8 per cent of our first admissions were returned to us for a second admission. Ten percent of our admissions were found to be unqualified for front line combat duty, but they showed sufficient skill or other qualifications to be retained in the Division for Limited assignments. Every one of these had made excellent adjustments in their new assignments.

The assignment of a Division Psychiatrist was not an easy one. Our original table of equipment was very limited. Although we were assigned to the Office of the Division Surgeon we drew our supplies from the Medical Battalion Surgeon and we often got only the supplies the Medical Battalion could do without and we often got the least desirable quarters to house our patients. Any recommendations to improve conditions in the Division which we offered had to go through channels. To obtain action through channels is a matter which I do not intend to discuss today.

Before I close I would like to make one suggestion: I believe that the Division Neuropsychiatrist could function much more effectively if he were made a junior staff member of the Division rather than have him assigned to the Office of the Division Surgeon.

THE COMBAT SYNDROME

Nils B. Hersloff, Major, M.C. *
Abraham Brodsky, Captain, MC. *

This term, Combat Syndrome, refers to the battle reaction as seen at the front lines. This may be an acute state precipitated by a shell concussion, or induced by prolonged arduous combat stress, or further, it may develop a day or two subsequent to hospitalization for shell fragment or other type wound. Personal experience with this entity, gained in the European Theatre of Operation and Southwest Pacific, relative to the psychoneurotic effects of combat experience, have led us to certain conclusions regarding this syndrome.

In contrast to the circumstances usually found in the development of what we might term the "civilian" psychoneurosis, it appears that, in very many cases of combat syndrome, there is a complete absence or very minimum presence of pre-disposing factors. The environmental and personal factors generally recognized as initiating or influencing the growth of a neurotic character are absent in many of the patients suffering combat syndrome. Neuropathic traits are not necessarily related to the syndrome. To the contrary, these same traits may propel the individual to extend himself, committing the most adequate service in a military sense to a point of exhaustion without developing the combat syndrome.

Combat reactions are only occasionally the result of a single experience as compared with the etiology and development of the civilian psychoneurosis. The syndrome is determined by such factors as persistent threatening situations, oppressive physical activity, intolerable living conditions and most traumatizing, in many instances, is the casualty of a "buddy" with the concomitant overwhelming loss of security and confidence derived from group psychology.

In combat syndrome, precipitating factors are sudden, less accumulative, lacking in chronicity and are unrelated to previous experience. It is recognized that long periods of combat service can create persisting cumulative reactions, but it is felt that these do not compare with the contributing factors to the civilian neurosis which may have been of years duration. It is also recognized that the fearful contemplations of pre-combat may influence the thinking and behavior of the individual although this factor does not appear in the syndrome of combat exhaustion. While the Army has recognized the need for establishing some semblance of combat experience through the battle conditioning phase of its basic training program, it cannot necessarily fully simulate the utter realism of battle. This element--the realism of battle--dismisses the possibility of fantasy in the development of the combat syndrome. Shellings, bombings and strafings

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produce no dream states comparable to the rich fantasy life of the civilian psychoneurotic.

Many mild civilian neuroses are held in check through rational escape mechanisms. In the precipitation of the combat syndrome escape is not a factor. The hell of combat can neither be rationalized nor escaped. The most severe reactions seem to have come from combat situations where there have been considerable holding actions or reversals such as occurred at Anzio, Cassino and the Belgian Bulge.

To reiterate for the purpose of emphasis, the clinical picture of the combat syndrome does not suggest previous neuropathy nor does it seem allied to the civilian types of psychoneurosis. At first glance, the patient appears enervated, lacking in interest except for displaying varying degrees of apprehension. Objectively the picture reveals apprehension, bewilderment, psychomotor retardation, poverty of affect, memory impairment, restlessness and irritability, to mention only a few, but nonetheless consistent elements of the syndrome. These cases have been followed through from the clearing station to the evacuation hospital, the station hospital, the general hospital and, finally, to the convalescent hospital, and generally the symptomatology differs little from that just described.

It is interesting to note that after evacuation and removal from the acute areas of precipitation, the patient very often develops a fixation of symptoms in order to assuage the super-ego and his consequent guilt feelings. The prognosis of the combat syndrome reveals a growing tendency on the part of the patient toward rationalization and utilization of defense mechanisms, all aiming at the alleviation or displacement of his guilt feelings. The need for self-justification becomes more evident. It is felt that the element of guilt becomes markedly present at the "ZI" stage of the combat syndrome and it may be well to suggest, at this point, that civilian agencies charged with the treatment of the discharged combat syndrome recognize that worthwhile endeavor, particularly that related to the war effort, will help the patient in satisfying his need for self-justification, his desire to be of service although removed from actual fighting.

Another impediment to satisfactory prognosis is the feeling of personal defeatism found in many patients. In others the desire for discharge is so strongly felt that he unconsciously retains his symptoms until medical discharge is assured. This attitude is not to be regarded as malingering, but should be viewed as symptomic.

Return to the Zone of Interior also brings about the inception of other factors which impede favorable prognosis and confuse, to some extent, the patient's clinical situation. Having been returned to a place near home and having frequent opportunities of renewing home ties, the patient absorbs all of the economic and social problems involved in his home environ-

ment. These problems have arisen, in the main, from his absence from the home and, recognizing this, he feels a definite responsibility. The alleviation of these problems becomes uppermost in his thinking and sooner or later his family anxiety becomes super-imposed upon those which have arisen from his military experience.

In an effort to deal with patients suffering from the combat syndrome for rehabilitation to duty or civilian life, various methods have been utilized. At the level of the convalescent hospital the therapy program consists of orientation, group and individual psychotherapy, vocational guidance, physical reconditioning and trials on a civilian level. The therapy utilized is both general and specific varying largely as to the individual needs of the patient. It is felt that the convalescent hospital is a definite aid in stabilizing the combat soldier and experience shows that the majority of patients are symptomatically improved and feel they have benefited by convalescent hospital care.

An interesting reaction in about ten per cent of the cases of combat syndrome became manifest at an early date in the patients' convalescence. This group was noted to have shown gradual, but progressive improvement for from three to four weeks subsequent to their return from furlough. Following this period, however, their condition was observed to regress approximating the level of the clinical picture on admission. Study of these cases demonstrated a sense of insecurity and lack of confidence pertaining to adjustment to civilian life. Hence, this problem aggravated, accentuated, and perpetuated the anxiety condition.

Psychotherapy in both large and small groups failed to check or alleviate this process. Individual attention, however, elicited the fact that firstly they had misgivings as to their immediate future in civilian life and secondly they were not only ashamed of this feeling of insecurity, but also were dubious as to their abilities, to compete on a civilian plane.

From a practical standpoint it was decided to inform the patient regarding his ultimate disposition, namely, separation from the service and then to give him a trial furlough of from five to ten days. This enabled the soldier to straighten out familial or domestic problems he was unable to cope with on his convalescent furlough as well as permit an opportunity to gain employment, and lastly to accustom himself to the routines of civilian living. When indicated these trial furloughs are often times repeated. In this manner the patient still retains the advantage of his rapport with his medical officer who has individually handled his case since the day of admission. If further psychotherapy is indicated, it is administered. Other problems of the patient also may be discussed more fully. When the patient is ready, and with the approval of his medical officer, he is separated from the service and is confident regarding his civilian adjustment. Approximately ten per cent of those boarded

by myself have required and requested such handling and benefited by this policy as shown by the amelioration of the remnants of the combat syndrome.

To summarize, we find that in the combat syndrome precipitating factors are sudden, lacking in chronicity and unrelated to previous experience. Civilian predisposing factors play a negligible part in the original picture and neuropathic traits are not per se related to the syndrome. Following evacuation to safe areas, symptoms tend to become fixed and guilt feelings become predominant, associated with feelings of personal defeatism. Return to the ZI, renewing family ties and responsibilities, frequently initiates new anxieties which are superimposed on the combat syndrome and hence alters the clinical picture. It is felt that a stay at the convalescent hospital prior to return to duty or civilian life materially aids the patient in resolving new anxieties and gives a better insight into his overseas experience.

DISCUSSION of COMBAT SYNDROME

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Major Hersloff and Captain Brodsky have presented a clinical problem which, though exhaustively witnessed and investigated during the recent years leaves much variance of opinion as to mechanism, dynamics, and exact nosological place among disturbances of mentation. In our sincerely motivated desire to save feelings and serve up a palatable label for those personality disruptions stemming from the horrors of World War II we have seized upon this dramatic and sympathy-provoking tag of "Combat Fatigue". Let us not be blind, as we were so long when we employed the term "Shell Shock", to the true nature and genuine understanding of this entity for the broad, sociological and preventive psychiatric implications involved in the problem. We, in our experience are cognizant of the fatigue factor in these men who, pounded and pounded again with repetitious, dogging fear, lose their resiliency and can no longer assimilate their fearful experiences. There is reasonable evidence to show, however, that no man can panic or break down as a result of a contemporary fear alone. We believe these patients have been saving up their fear and carrying large volumes of inexperienced fear below the level of consciousness. This has been occasioned by very early psychological happenings which heretofore have not given rise to neurotic expression because no trauma with the impact of that experienced in combat threatened the organism. Were I asked what single psychological factor operates most prominently in producing combat fatigue, I would answer, "Insecurity"; tremendous, overwhelming, inescapable, acute insecurity from which there is no solace except through the development of a mental illness. We have found that great numbers of our patients come from broken homes, family relationships disrupted by death or divorce; that they were boys still conscious of their having been rejected as children; boys who lacked parent ideals, and boys who never had the sense of belonging to a family. These lads, then, are face to face with the most critical test of stability, the most threatening situation they have ever experienced. Here they meet uncertainty and insecurity and meet it consciously, unmasked in its bare, stark naked reality. By virtue of their early deficiencies in emotional development, insecurity has always been prominent--for the most part, unconsciously, prior to this--but now it comes as a gross and terrible experience crashing down upon them.

When the factor of insecurity is thus understood in the total picture of the Combat Fatigue, it becomes even more readily understandable why these boys who have seemingly made good progress toward recovery, regress when subjected to situations fraught with the same threat while on furlough or on convalescent leave.

We have found such occurrences therapeutically advantageous

in working through with the patient the realization that he needed something more than just food and rest to return to a state of efficient, comfortable functioning. One cannot predict whether these patients would or would not have broken down later on in life. It might be assumed that being repetitiously subjected to traumatic life experiences, which would activate the insecurity principle lying dormant and waiting for expression, that they would.

The challenge which this problem brings to the Social Sciences is tremendous for if we are to execute a dynamic preventive program for this and allied neuroses, it will not be enough to afford concentrated vitamin foods and adequate rest for our soldiers and sailors, but more important--adequate opportunities for healthy growth and development from childhood on. With the success of such a program we may hopefully move toward the day when there is no longer not only "Combat Fatigue", but the mass neuroticisms which contribute to the making of war itself.

NEUROSIS, NEUROTIC REACTION AND MOTIVATION

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Few of us, before the present conflict, have had the opportunity to observe, so closely, how the personality functions under stress. The intimate contact which the military psychiatrist has had with men under the varied conditions of military life, the observations of the effects of separation, group thinking, motivations, interpersonal relationships, regimentation, self-protective behavior drives, racial and cultural standards, indeed the whole gamut of physical, environmental and psychological onslaughts against the total personality have provided the psychiatrist with an unusual opportunity to widen his scope and to cause reorientation in his thinking regarding emotional reaction and illness. The war situation with its ever present threat against individual security in combat, yes against the very existence of the individual in his battle for survival, has frequently fully exposed the innermost part of his emotions and "crudely removed or completely stripped its veneer."

At the beginning of the war the military psychiatrist had to use as his measuring stick in diagnosis the experience and diagnostic criteria which he acquired in civilian practice. Civilian and army diagnostic standards were in the main closely akin. As time went on our army experiences began to make us more acutely aware of the part played by sociologic, cultural, and physical influences to individual tolerance to stress, and we then began to note that our nomenclature and standards of differentiation between normal emotional reaction and abnormal emotional reaction to the army stress factor with all its component influences was not as clear cut as we had previously imagined. Furthermore, experience quickly taught us that to use such a common term as psychoneurosis and apply it to individuals who were temporarily incapacitated by reaching their limit of tolerance to physical and mental stress was not specifically applicable in all situations, and often presented the soldier with a stigmatizing handicap which would greatly interfere with his later civilian adjustments and relationships. The lack of clear understanding both by the laity and some professional people, oftimes further confused by so-called scientific double talk explanation, brought us to the stage wherein we were challenged to evolve from experience gained, a better set of concepts for diagnosis and, what obviously follows, a more concrete method of treatment principles.

In this paper an effort is being made to evaluate the difference between neurotic illness and reaction. It is admitted that differentiation is frequently difficult. If we are to attempt to separate the two it becomes necessary to attempt a definition of terms. It is unfortunately not possible to give a precise definition of the term "psychoneurosis." Many writers only attempt to describe the symptoms, divide them into symptomatic categories, but fail to point out the line of cleavage between

the end point of normal reactions and neurotic illness. It is a general working principle that when symptoms impede the efficiency of the individual and prevent him from leading a reasonably happy, adjusted existence, neurotic illness is to be assumed. The duration and extent of the symptoms, and especially the effects of removal or alteration of the causes which produce the symptoms, are important in determining the existence of pre-existence of a neurotic illness.

Neurosis:

The neuroses are disorders of behavior and somatic function arising out of the difficulties which individuals meet in gaining satisfaction of their needs in the cultural milieu of which they are a part. These needs are of three primary categories: 1) the biologic needs of nutrition, sex and protection during helpless periods of life, 2) the culturally inculcated needs of prestige or status in the social group, and 3) the need to discharge hostile aggressive tensions resulting from the frustrations of the biologic and cultural needs. The factors determining the occurrence of neurotic symptoms in an individual are: 1) the degree of integration of the self or personality, and, 2) the current frustrations of his needs.

At times we have been all too prone to assume that a war traumatic experience is one which produces a psychopathologic state out of the clear; yet, when investigation is sufficiently painstaking, it is rather unusual to find a case in which evidence of pre-existing psychopathologic characteristics cannot be detected in the previous history. It is very common to find that a soldier suffering from a neurosis acquired in war has a previous history of neurosis acquired in civilian life. It has been an observation of psychiatrists in this country and those abroad that in an appreciable percentage of military cases, the trauma upon which a "war neurosis" supervenes is found to be one which is only incidentally associated with conditions of war. No more often is seen in the true neuroses in war an exacerbation or a precipitation, by the traumatic war experience, of a pre-existing but hitherto latent psychopathologic process.

Essential in the formulation of the diagnosis of a neurosis are not only the overt symptoms which are observed at the time of examination, but, more important, a careful study and review of the longitudinal life history of the individual, taking into consideration all of his inherent attributes and weaknesses, his experiences, environment and his overall ability to make adjustments to precipitating stresses. All too often will we find that the true neurosis has contained within it the element of chronicity. Perhaps the symptoms are not present to the degree seen in the threatening army or combat situation, but nevertheless in a milder pre-existing form.

In a statistical review of 1521 neuropsychiatric patients studied at Percy Jones General Hospital from February 1943 to September 1945, 1104 or 73% of this total first manifested emotional symptoms in the zone of the interior or non-combatant area. The

symptoms were sufficiently marked to warrant hospital treatment or investigation. The remainder of the total group, 417 or 27% first manifested acute symptoms in combat. Although investigation of individual records of the 1104 patients was not thoroughly made in this review, indications are that these patients in the main had neuropathic traits prior to induction into the service. It is not to be assumed that frank neuroses do not occur under army stress without previous healthy psychiatric history, but the incidence is relatively low.

Neurotic Reaction:

The majority of reactions to combat situations are of a relatively mild degree and it is these reactions which, if treated promptly, are short lived and do not produce lasting disturbances of emotional function. Experience has clearly shown that fatigue and fear are normal concomitants of combat. In the well integrated person who is subjected to bombing, shelling, physical hardship and all associated stresses of battle situations for indefinite periods, the physiologic response to be expected is that of fatigue. As noted by Braceland and Rome, and many others, deprivation of food, constant threat to life and absence of rest, eventually will produce a breaking point in any individual, with resultant symptoms of irritability, restlessness, startle responses, autonomic nervous system symptoms, and, in more severe instances, personality changes of depression, anxiety, panic, apathy, confusion. It is this set of conditions and symptoms which in my opinion should be separated from the group labelled the neuroses, and instead should be classified as neurotic reactions. It applies to a certain group of patients, previously well integrated, who have been exposed to conditions which were close to or beyond the limits of physical and emotional endurance. Their response at the onset may be similar to the neurotic, yet different in that the recovery usually ensues with early treatment. Attention to the physiologic and psychologic needs, suggestion, desensitization of the ego, reassurance and providing, by explanation, the development of insight into the mechanisms involved in the production of the symptoms are necessary treatment procedures. The navy designates this group as "combat fatigue," the air forces "operational fatigue." Braceland and Rome note an important differentiating point; namely, that in the neurotic personality "the patient's fatigue is not only proportional to his anxiety but is also induced by it." In the well integrated, stable individual confronted with combat stress, who has gone beyond the upper limits of tolerance, fatigue is the major factor producing secondary anxiety response.

The importance in differentiating between neurosis and neurotic reaction is not only of value in prognosis and method of treatment, but, in the case of the neurotic reaction which has been properly treated and recovered, the soldier will not be later stigmatized and carry a "neurosis" label into civilian life. In some instances he will not be able to use his label for secondary gain later on. I refer to pensions, undeserved demands for sympathy, special considerations, etc. The very favorable and gratifying response to therapy of the group classified as neurotic reactions has led many observers to the opinion that

such reactions arising in combat are not generally deep rooted and they do not fundamentally represent life long problems, but rather symptoms of acute maladjustment to intolerable situations. I am in agreement with Pastor and others that if these patients are treated promptly, reclassified, and placed in non-combatant units immediately after the onset of their symptoms, the majority of them will continue to function in the army. They will then return to civilian life at the end of the term of service not as invalids, but as healthy individuals who have actually done their share to the best of their ability.

Motivation:

Much has been written and considerable emphasis has been placed on the part motivation plays in the mental health of the soldier. The intimate relationship between neuropsychiatric disabilities and morale with its foundations of good leadership, discipline, good mental health, group spirit, indoctrination, orientation, and rear echelon efforts are well known by this time, so I do not intend to discuss them here. The unconscious struggle between the demands of the instinct of self-preservation in attempting to remove the individual from the path of danger and the conscious element of requirement to fight, fear of reprisal by members of this fear, the indoctrination and orientation efforts, certainly produce a serious conflict in many men. In the ineffective unit in those who have succumbed to "combat fatigue", which could not be broken until the disintegrating stress was overwhelming them, this conflict without doubt has had many psychologic repercussions.

In the group of neuropsychiatric disabilities returned from overseas the motivation factor and attitude toward further army service has in many instances been observed to be at a low level. All too often has the psychiatrist been faced with the question, "How is it possible to produce improvement in the patient, when his motivation toward service is at so low an ebb?" The element of gain by regression into lasting illness as a means of protecting the individual from further army threat is not infrequently a major problem to contend with. I am sure that frequently poor motivation is a barrier to resolution of symptoms.

Separation from the group and loss of unit identification by hospitalization and evacuation to the zone of the interior is a factor, among many others, which sometimes changes the attitude and motive for service from good to poor. This is particularly noticeable in the inept, the psychopath, and in the soldier who has had a past history of maladjustment and unhealthy behavior pattern. The psychiatrist must in such cases make a thorough investigation into the part that motivation plays in the overt psychopathologic symptoms which the patient presents. To accept the patient's statements at face value and not thoroughly investigate the individual as a whole and determine his prior reactions to similar stress situations will lead to erroneous dispositions, and, what is equally important, will give the patient a crutch upon which he can lean the rest of his life to compensate

for his failure in adjustment in the future. The soldier patient not infrequently in the presence of the psychiatrist utilizes all of his conscious and unconscious defense technics to seek the help of the psychiatrist to remove him once and for all from the army threat and to be the medium whereby he can return to civilian life. We must not fall into the error of making snap decisions either in regard to the intensity of the neurosis, reaction, or motivation, but allow ourselves time and observation of the patient. Knowledge of how he relates himself to his fellows outside of the doctor's office or direct observation is vitally necessary. Does he show emotional symptoms in the barracks, at home on furlough, in town in the company of his fellows in the evening, in the recreation field, in the O.T. workshop, in reconditioning, is a question which must be answered. What influence is his family having on the soldier's attitude and motivation, now that he has returned home? What does the psychiatric social history reveal? Is diminished or absent motivation primarily due to illness, or was it a major factor in producing signs of illness? After the patient has received careful psychiatric evaluation and treatment, the psychiatrist is then in a better position to decide what the patient's disposition should be. If poor attitude and motivation are the remaining findings they should so be recorded, and these factors cannot be used as a reason for proving medical disability.

The War Department in its circular 81, dated 13 March, 1918, clearly recognizes the effect of poor motivation and attitude, stating, "There has been a tendency to attribute noneffectiveness to coexistent medical defects such as flat feet, lumbo-sacral strain, or mild psychoneurosis, when actually these defects were not in themselves significantly disabling and the primary cause of the noneffectiveness was nonmedical, e.g., inaptness, inadaptability, defective attitudes."

Defective motivation and attitudes in the absence of incapacitating psychiatric illness, if allowed to be considered a part of illness and considered a medical disability, will not only prove detrimental to unit morale, but is plainly a sign of haphazard psychiatric thinking. We have all too often seen what remarkable adaptations are made by men with valid neurotic illnesses to army assignments for which they are psychologically fitted. Poor motivation and attitudes are not primarily components of illness.

Psychiatry has received excellent recognition during this war and has gained a greater place of prominence in medical practice than ever before. It behooves all of us to utilize the experience which we have gained in the understanding of emotional problems so that in our future civilian practice this knowledge can be made more useful to the welfare of the individual, community and nation as a whole.

NEUROSES, NEUROTIC REACTION AND MOTIVATION

Discussion by Francis J. Gerty, M.D., Professor and Chairman of Department of Psychiatry, University of Illinois

In civilian life the succes of an individual is measured in terms of his ability to bear his own special responsibilities and his fair share of the group burdens. To fail--to fall below a somewhat indefinite acceptable minimum in these things, is looked upon either as justifying blame because of a lack of moral fiber, a "badness" of some sort or degree, or else is excused as being due to misfortune or illness.

The stresses of civilian life are commonly less discernible, less definable, and usually less dramatic than those of military life during war. Further, in a military service, his portion of the group burden is directly and uncompromisingly thrust upon the individual. His responsibility to and for himself becomes of secondary importance. His choice, his pleasure, his profit, his safety are matters about which he can determine only what military regulations permit, which is much less than he is accustomed to determine. Nevertheless, all men in the military service grew up as civilians and expect to be civilians again, a matter of some importance for the future. The fundamental mechanisms acting in them are those of the civilian, but these mechanisms are put into operation under unusual and severe test conditions of a somewhat more uniform nature than the tests of non-military life. The special tests and stresses act selectively to bring out a greater percentage of some special sets of reactions than would appear in civil life. Taken altogether, it is to be expected that the general effect of stress will approximate that observed in the same material under non-military stresses. Good motivation, i.e., good attitude or good moral fiber, a thing of some complexity as to origin, will produce the good citizen and the good soldier. Lack of this quality is thought of as a defect of material rather than as an indication of illness. How this defect comes about and how it may be distinguished from neurotic illness are questions not easy to answer.

As to neurotic reactions, I think that is may be granted that in less striking forms they are of common occurrence in everyday life, but we have become so accustomed to them that we pay no great attention to them especially since they are usually mild in manifestation. Combat, fatigue, and danger should produce them in more dramatic form even in persons who are ordinarily quite stable.

The lesson I draw from Dr. Turow's paper is that a method of adequate examination of the patient and of the facts in his whole life history gathered from reliable sources is of paramount importance if we are to distinguish between the ones who will bear burdens and the ones who will be burdens under the conditions of military service. Motivation, with the reservation I have suggested, is the touchstone which in actual test will separate the fit from the unfit. It will also be connected with some differences between two types of the unfit, those who will not bear full burdens, the psychopaths, and those who cannot, the definitely psychoneurotic.

RESIDUALS OF COMBAT INDUCED ANXIETY

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It is inevitable that demobilization will release from military service a number of veterans still experiencing residuals of combat induced anxiety. Veterans' clinics, civilian psychiatrists and physicians generally are seeing these men now. Some may need prolonged care; many, possessing a more stable personality structure, will need little more than an opportunity for insight and psychological reorientation in peacetime and civilian pursuits. In the neuropsychiatric section of a general hospital serving a large metropolitan area we have had an opportunity to observe and treat a number of patients near to separation from the service whom we believe present problems common in veterans' clinics today. Some were admitted from pass or furlough because of acute emotional disturbances while others were referred from the medical and surgical services within the hospital. A significant number of these patients gave no history of neurotic determinants before they were overwhelmed by excessive and harrowing combat experience. A greater number noted the onset of symptoms to days or months following evacuation from the battle zone although the disorder was similar, though less intense, to that usually designated as combat exhaustion in the forward areas. It is this group of relatively stable, mature and well adjusted individuals whom we have designated as suffering from residual anxiety reactions for the purpose of emphasizing their specific therapeutic needs and good prognosis as contrasted to the more classical types of psychoneurosis.

In general, the residual anxiety reactions showed many similarities to the usual types of neurotic illness but they differed, as Goldstein pointed out, in that no fixation of symptoms or fundamental personality change had taken place at this hospital level. They showed no more established than "combat exhaustion" which the commission of civilian psychiatrists, reviewing the psychiatric policy in the European theatre, reported did not correspond to any recognized or established psychiatric syndrome. The differences were apparent in a comparative study of thirty-six residual anxiety states and an equal number of individuals presenting symptoms of psychoneurosis whose histories were indicative of neurotic adjustment in the past.

Onset of Symptoms

All of the residual anxiety group had experienced combat of varying severity and duration. The established psychoneurotic group had been overseas but only twenty had had actual battle experience. Their exposure to battle conditions had been much less severe and prolonged for they showed an approximate average of thirty-six days in combat compared to seventy-eight and nine tenths for the former.

Study of individual cases revealed many different factors

responsible for the final psychoneurotic disablement in those predisposed. Thirteen developed symptoms while stationed in non-combatant bases -- three while in isolated outposts in the Aleutians and one in Labrador. Symptoms of equal severity had been present before or since the day of induction in four individuals. One patient claimed that his symptoms had not developed until he entered the hospital for a second wound which appeared to be self-inflicted; another developed multiple complaints while recovering from an injury incurred in the rear echelons of supply. A marked increase in tremulousness while aboard ship returning to the United States was noticed by a medical aid man. One medical officer and a tail gunner, who had been a prisoner of war after bailing out over Germany, developed acute depressive reactions after returning home and learning of the infidelity of their wives. The twelve patients whose symptoms were precipitated by combat differed from the residual anxiety group in the character and fixity of their complaints. Four of them obviously exaggerated disability resulting from wounds or injuries. One dental officer became extremely depressed after three busy months in a battalion aid station. One soldier ran to the rear as soon as he was placed under artillery fire; an officer covered in his fox hole and was totally useless as a leader of troops from the outset of battle; one developed an hysterical amnesia and a multiplicity of persistent gastro-intestinal complaints; and a schizoid gunner developed many paranoid ideas before he was relieved of duty because of a flak wound.

The ten patients in the residual anxiety group who developed symptoms in combat did so only after prolonged or harrowing experiences. Severe stuttering occurred in one patient after a prolonged advance through the hedgerows of France. He recovered after five days in a rest camp only to break again when next exposed to the sound of artillery fire. An enlisted man who had been through four major battles and a total of one hundred days of combat in the Pacific did not develop symptoms until he was subjected to bombing of the hospital where he was confined because of a severe arm wound. One patient was blown out of his plane and fell 14,000 feet before he could open his damaged parachute; another could not continue after losing three planes to enemy fire in five days. An officer in a holding position subject to nightly Japanese infiltration attacks and daylight bombing raids developed symptoms which persisted after he was returned to the United States on rotation. A lieutenant who had served successfully throughout the African and Sicilian campaigns broke down after he had led five attacks into Cassino in three days. A near burst of an artillery shell caused unconsciousness and bleeding from his ears and, when he tried to carry on, he was unable to control his weeping and tremulousness. Latent symptoms developing in twenty-three patients after removal from battle zones were similar to those developed in combat. Six of this group were accompanied to the hospital by frightened relatives who had witnessed a terrifying nightmare or had become concerned about the patient's behavior.

Symptom Analysis

It is difficult to show clearly the differences observed in the psychiatric examination of the two groups although here the tense, hesitant, somewhat defensive individual who is suffering residual anxiety is most unlike the established psychoneurotic. Patients were encouraged to list their complaints with as little guidance from the therapist as possible. The psychoneurotic usually gave a good account of his symptoms with little prompting while patients in the residual anxiety group were more often reluctant to speak of their experiences and frequently showed embarrassment during the initial interview.

The leading symptoms in the two groups were summarized for comparison. Tenseness and other symptoms typical in "combat exhaustion" were more prominent in the residual anxiety states while phobic reactions, hysterical conversion symptoms, somatic complaints and depression were more often encountered in the psychoneuroses. Somatic complaints were common in both groups but there was little evidence of fixation of anxiety in the former. Headache was as frequent in one group as the other, although only two of the psychoneurotics had a definite history of exposure to blast as compared with twenty-three in the anxiety group. The blast was of sufficient force to produce unconsciousness in five and tinnitus was present in six. A sense of "dizziness" was not mentioned in any of this number although it occurred six times in the psychoneurotic group.

Little is known concerning the role of blast concussion in the development of "combat exhaustion." Most men who have seen the amount of combat encountered in our group must have been exposed to some blast. In at least four patients blast concussion may have been partially responsible for their removal from combat although three had other wounds. In several removed because of combat exhaustion, exposure to near burst of artillery shells seemed to serve as the final precipitating blow in their breakdown.

Treatment

The good response to brief psychotherapeutic procedures and an activity program designed to permit a gradual strengthening of the patients sense of personal security through contact with civilian life first led us to distinguish the residual anxiety states from the more fixed psychoneurotic reactions. Treatment was conducted on an individual basis. The patient was encouraged to relate his symptoms and an attempt was made to reconstruct associated events on a conscious level. When this could not be accomplished easily hypnosis techniques were employed. In our experience hypnosis accomplished the same results obtained with sodium amytal or pentothal sodium interviews. We are in agreement with Hart and his associates who believe these drugs merely facilitate hypnotic therapy. The same violent reactions on recollection of traumatic scenes of battle, often with marked expression of guilt, were obtained with all methods. The intensity of the response seemed directly related to the horror of the combat experiences. All patients reported subjective relief from tension after undergoing one of these "abreactive" sessions.

It was necessary to repeat the procedure in some although continued improvement was most dependent upon additional psychotherapy. The material gained in various interviews was reconstructed in consciousness and was gradually related to past and current experiences as treatment progressed. In addition to participation in the recreational and occupational therapy program within the hospital, patients were urged to take advantage of free pass privileges in order to increase their contact with civilian activities. Thus, attitudes toward friends and relatives, hopes and ambitions for the future as well as attitudes toward symptoms and military experience became the basis for further explanation and reassurance. Dependent attitudes were discouraged. The fact that symptoms often subsided after admission to the hospital from furlough or pass stimulated discussions of dependency upon a known military regime in more than one case.

The mode of onset and duration of symptoms had little effect upon accessibility for treatment. We have seen one case in which nightmares developing after the last war were relieved twenty years later. A heightened suggestibility is apparent in some cases. This may lead to apprehension concerning the significance of symptoms if not actual displacement of anxiety. At least one case in this series first became fearful of heart disease after a medical officer had casually asked him if he knew he had heart trouble. The fact that he had been able to withstand the rigorous physical demands of prolonged combat was overlooked by both the patient and his doctor. There does appear to be a real possibility that free anxiety noted in this group of patients may become translated into functional disturbances.

The neurotic fixation of anxiety apparent in the psychoneurotic group followed patterns established before combat experience. Treatment of phobias, conversion mechanisms and somatizations remaining after the acute reactions induced by battle situations had subsided was not very satisfactory. In the residual anxiety group whom we have segregated, treatment usually resulted in the establishment of a healthy orientation and return to a level stability with little evidence of neurotic displacement or fixation. This difference points toward the specific traumatic experiences of war as the significant etiologic factor in the development of symptoms in this group.

Discussion

Much has been written concerning the dynamics of the "war neuroses" since the evacuation of Dunkirk and the bombing of London. Brief, direct methods of treatment have afforded an opportunity to explore and relieve the acute reactions. Two generalizations have come out of this approach which appear particularly applicable to this group whose residual anxieties we believe to be a specific product of their war experiences; namely, anxiety is the basic problem in the war neuroses, and; even the most stable individual will show "neurotic" breakdown if subjected to stress beyond his individual level of tolerance. This breakdown appears to be a final mastery by more instinctual patterns in the struggle against the idealism and group loyalties

which have controlled behavior as a respected member of a combat team. The acquisition through military training and discipline of ego strengthening devices which prepare the individual for the combat situation has been discussed by Grinker and others who speak of "combat exhaustion" as resulting from a final disintegration of the weakened ego in the face of overwhelming anxiety.

Several different factors seem to be responsible for the continuation of symptoms or their latent development. Identified as a member of a group the soldier exerts strong suppressive forces to hold anxiety in check. These are no longer so necessary when he finds himself removed through wounds or other illness to a hospital in the rear. The outlet for aggression which has been focused upon a common enemy is no longer available to him and he finds behavior acceptable and unnoticed in the battle zone in conflict with what is now expected. Gillespie in commenting on the latent period, mentioned the role of suggestion either from within or without in the development of symptoms. He noted that so long as individuals were kept busy they were less likely to develop symptoms, but that given an opportunity, rumination over events experienced rather than perceived often led to additional meanings. One of our patients expressed this when he said that his symptoms did not develop until he arrived in a hospital in Paris and began thinking of his narrow escapes. Guilt feeling often expressed as a sense of failure in responsibility to the group and depressive reactions growing out of reflection over participation in some noxious act of aggression were seen as an elaboration of this mechanism.

Some symptoms we have observed are best explained as conditioned responses. The seasoned soldier soon learns the meaning of sounds and responds to them automatically. The startle response often persisted after many other symptoms had been relieved. The slight scraping of a chair behind him caused one of our patients to suddenly freeze. He had been engaged in sabotage behind enemy lines and had become adept at evading the enemy. Lightning, the back fire of an automobile exhaust and other unexpected noises often caused sudden increase in muscular tension, palpitation and visceral sensations which as quickly disappeared when the situation was perceived. Generally, such reactions became less bothersome with relief from tension, elapse of time and reorientation.

Most soldiers show an increase in anxiety on return home--some of them admit apprehension. Most of them have a fanciful concept of the home to which they have yearned to return, still, after the first joyous reunion, their own strangeness becomes apparent to them. The realities of the challenge in future adjustment where they must again assume responsibility for themselves and others when they have had little time to recover from the isolation of functioning near to primitive levels serves as a further source of tension which may bring to the fore the residual unresolved anxieties induced by combat. Undoubtedly, the majority of returning veterans will find security in old civilian patterns with a minimum of emotional disturbance. How many will

encounter insurmontable frustrations leading to dependent neurotic attitudes in the future must still remain a matter of conjecture.

SLIDE I

ONSET OF SYMPTOMS	Psycho-neurosis	Residual Anxiety State
Before military service	2	0
Since day of induction	2	0
In overseas base (no combat)	13	0
In combat	12	10
While prisoner of war (German)	2	3
In evacuation or U.S. Hospitals	2	10
On ship enroute to U.S.	1	1
Upon return to U.S.	2	7
On furlough from overseas	0	5
	36	36

SLIDE II

SYMPTOMS	Psycho-neurosis	Residual Anxiety State
Tenseness	24	36
Tremulousness	7	19
Battle Dreams	1	16
Startle reactions	2	15
Sleeplessness	2	14
Disturbed by noise and confusion; poor adjustment to civilians	2	14
Restlessness	4	12
Irritability	2	11
Somatic symptoms	19	11
-cardiac	3	6
-gastrointestinal	14	3
-respiratory	0	1
-urinary	2	1
Headaches	10	10
Dizziness	6	0
Tinnitus	0	6
Depression	13	7
Morbid fears, doubts, compulsions	11	0
Hysterical conversion symptoms	7	1

RESIDUALS OF COMBAT INDUCED ANXIETY

Discussion by Hugh T. Carmichael, M.D., Associate Professor of Psychiatry, University of Illinois.

Captain Sturdevant has called to our attention again the need for differentiation between two types of individuals who, when exposed to combat during military service, may manifest clinical symptoms usually regarded as indicative of neurosis. One of these types is that of the individual whose past history shows no evidence of so-called neurotic trends, but who under the stress and strain of combat experiences finally reaches a point where he can no longer tolerate the demands made upon him and develops reactions which overtly resemble the picture usually called neurotic or psychotic behavior in civilian practice--the so-called state of "combat exhaustion." The other type is the individual who may also break down in combat but in whom there is a past history of so-called neurotic behavior or trends. This type of individual tends to succumb to the stresses of combat at an earlier period than the first type and tends to have more fixation of symptoms and to be more resistive to treatment than the first type. I believe it is most important to be aware of the differences between these two types and to be on the alert to recognize them.

The hypothesis that there is a difference in the two groups of patients is supported strongly by Captain Sturdevant's convincing demonstration of the symptom picture and better response to a therapeutic approach conducted primarily at the conscious level in the "residual anxiety group," and the need for "deeper" and more intensive methods of psychotherapy in the "psychoneurotic group."

The question of the effects of exposure to blast is an interesting one. It may be that in addition to acting as one of the immediate precipitating factors in the production of symptoms during combat, blast may well have occasioned in many of the individuals exposed to it some bodily injury which is difficult to recognize with the usual clinical tools. I think in this regard, especially of damage to the brain. In some of these patients, it may well be that the residual anxiety is more directly related to the attempts of the individual to meet the usual demands made upon him either in the hospital environment or in civilian life-demands which he has great difficulty in meeting adequately due to the defects caused by the brain damage, with the resultant appearance of symptoms which seem to be neurotic.

Why was the first appearance of symptoms delayed in twenty three of the residual anxiety group until after their removal from the battle zone? And why in the other members of that group, did the symptoms which began during combat continue for such a long period?

I believe that Captain Sturdevant is correct in his assumptions that removal from the combat group of which he has been a member deprives the individual of the support he had as a member of

the group, and thus makes him more vulnerable to his own individual anxieties, fears and guilt feelings; and that it also deprives him of acceptable outlets for direct expression of his aggressive trends, and subjects him too much opportunity for self-examination and rumination over his battle experiences and self-recrimination about his failure (as he sees it) to carry his full share of responsibility with the rest of the group. With the removal of such supports as were afforded by the group, the weakened ego succumbs to the anxiety which it had previously been able to master and resorts to an attempt at mastery by the use of more primitive patterns of behavior.

I believe it is possible too that the increase of anxiety on return home might well be occasioned by losing the support of the military environment and having to face the lack of understanding on the part of civilian friends and relatives, as well as the quite different demands made on the individual as an individual in civilian life as contrasted with those made on him as a group member in the services.

I heartily concur in Captain Sturdevant's concluding remarks that the majority of veterans will be able to find security in civilian life with a minimum of emotional disturbance. They will need to accomplish this smoothly with assistance of the sort given by Captain Sturdevant to his group of patients with residuals of combat induced anxiety; that is a gradual reintroduction to civilian status with support and guidance during that period.

DEEP AMYTAL NARCOSIS IN THE DIAGNOSIS OF HYSTERIA

Franklin O. Meister, Maj., MC*
Stanley W. Conrad, Capt., MC*

During the present war, a good deal of attention has been given to the diagnosis and treatment of the emotional disorders. This emphasis has not been limited to any one zone of operations nor to any one type of medical installation, or to any special group. The surgeons, the internists, and particularly the medical officers, in the aid stations of the forward areas, became "neurosis conscious". This awareness of emotional disorders played a major part in the early diagnosis and the prompt treatment which, as you know, obviated the necessity for evacuation in a high percentage of such casualties. One would expect that the passage through the successive units in the chain of evacuation would quickly reduce the number of undiagnosed neuroses. On arrival at the final unit in this chain, the named general hospital, only the rare case should be a problem in diagnosis.

Our experience in the consultation service of such a general hospital would indicate that this is generally true. However, we did come upon a number of such undiagnosed cases. In most of these the diagnosis was difficult and in all, the initial therapeutic efforts were tedious, time-consuming and discouraging. A review of our own difficulties with this group of patients would indicate that any implied or expressed criticism of the medical officers who had previously cared for them would certainly be unjust.

The primary reason for hospitalization in this group was surgical, and all of them had been evacuated to the Zone of the Interior as surgical patients. The injuries in all instances had been severe and the immediate therapeutic indications had been surgical during the major portion of the previous period of hospitalization. The problem, as it presented itself to the ward surgeon when the patient arrived in the general hospital, was, on superficial examination, no different from that found in the majority of his patients. The record would show a number of severe and mutilating wounds which had required a series of operations and usually some surgical manipulation as well as the use of some form of traction or splinting. Preliminary examination would reveal a number of contracted and perhaps adherent scars; the evidences of loss of muscle tissue from atrophy and from the mutilating nature of the original wound; and a disability that might be explained on the basis of these injuries and their residuals. With more detailed study and with longer observation, it would appear that because of the slow progress and the severe handicap, some additional explanation was necessary. At this point, neuropsychiatric examination would be requested with a suggestion that the residual disability might possibly be the result of a previously unsuspected involvment of the peripheral nerves. At times, however, psychogenic factors were suspected and the reason for consultation would be stated as: "Disability out of proportion to

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organic findings".

Though the problem was ostensibly a neurologic one, and though the approach during the consultation would be on that basis, the suspicion of significant psychogenic factors usually could not be avoided early in the interview. Such suspicions were aroused by the brief and sketchy history and by an initial attitude of indifference toward the examination. It would be difficult to obtain a reasonably clear account of the injury and of the residual disability, even with direct and leading questions, and the patient would frequently refer these questions for details to the injured part with a remark such as, "There it is--you look at it and tell me about it". Having assumed from such behavior that the psychogenic factors were probably responsible for the disability, and that a careful neurologic examination would solve the problem, the patient would be asked to disrobe. After that, only a glance at the injured extremities would be sufficient to indicate that the problem could not be solved in such a simple fashion. The large and multiple scars, the loss of muscle tissue from the original debridement, and the localization of the injuries would tend to support the suggestion that some damage to the peripheral nerves had taken place. The bizarre sensory disturbances and the profound motor impairment noted on the examination did not make the differentiation of a psychogenic disorder, from the residuals of the organic injury an easy task. The poor cooperation of the patient, obvious indifference toward the examination, and the vigorous objections to repeated examinations added greatly to the difficulty of establishing a clear-cut evaluation of the various factors involved. The patient not infrequently stated his objections to any sort of "psycho" diagnosis long before that question had been settled in the mind of the examiner. Repeated examinations and the utilization of the usual diagnostic aids were of some help, but the final evaluation would be expressed with some hedging and with some doubt. It would seem that much of the confusion would arise because the strong suspicions of psychogenic disorder that came up during the interview would conflict with the feeling that multiple and severe injuries of the type displayed on the objective examination might very well explain the disability.

When the confusion and doubts concerning the diagnosis had been settled in favor of an emotional disorder, the much greater problem of therapy added further difficulties. All of these patients had spent long periods receiving the surgical treatment required for their injuries. They had been given a good deal of attention and much of this had been focused on the injured extremities. They had become quite adept in the use of canes, crutches and wheel chairs, and had formed a sort of attachment to these devices. In addition these aids had become, in a sense, the external signs or badges of a disability acquired in combat and were used to evoke a certain amount of attention and sympathy. The firm conviction that the disability was organic, fostered by long periods of necessary surgical treatment, as well as the need for some obvious badge of illness such as a crutch or a cane, created in these patients a tendency to resist any

therapeutic attempt that might alter the "status quo". In addition, they were suspicious from the very beginning of anything called neuropsychiatric and were usually only too ready to object to any procedure that might bring them into that category. Many of them seemed to have the idea that this thing they called "psycho" was something given to them by the doctor for some kind of misbehavior and they were positive that it would not have any relation whatever to any symptoms they might have had. They objected to being transferred to the Neuropsychiatric Service, and as the attempts at psychotherapy were being instituted, the indifference and poor cooperation expressed during the original interview were replaced by resentment and frank hostility.

We first used narcosis with the hope of resolving the doubts that so frequently arose during the preliminary examination in what was ostensibly a neurologic problem. It was our intent to obviate the need for repeated examinations and more important, to prevent the patient from suspecting that there were any doubts as to the correct diagnosis in the mind of the examiner. Though at times we did experience some difficulties in evaluation of motor functions under narcosis, we found them to be minor when compared to the results of the examination without narcosis. The evaluation of the sensory findings under narcosis also was surprisingly easy. With the deeper levels of narcosis, the resentment and hostility were greatly reduced and this procedure, which had originally been an aid to diagnosis, became a basis for the initial psychotherapeutic approach as well. After the first period of narcosis, the patient was permitted to remain on the surgical service until much of the resentment and hostility had disappeared, coming to us only for therapy under narcosis. When he was finally transferred to the Neuropsychiatric Service, he usually had no further objections and was able to continue his therapy in a routine fashion.

The poor cooperation during the initial examination, and the intense resentment to treatment shown by these patients, suggested that the deeper levels of narcosis were essential for our purpose. In all those instances where more superficial levels of narcosis were used, the results were not at all good. Sodium amytal by intravenous route was chosen for the production of the deep narcosis. It could be given in large doses with relative safety and the level of narcosis could be maintained with ease. It is said that the percentage of untoward effects with this drug is smaller than that with some of the other drugs used for narcosis. Our own experience, though rather limited with these other drugs, would indicate that sodium amytal is the drug of choice for the production of deep narcosis.

The method used in these cases is not new, though it should be noted that the use of picro toxin for better control of the deeper levels of narcosis is significant. The usual procedure for narcosis was used. The room selected was quiet, not too brightly lighted, and contained only a bed and a chair, and at times a small bedside table. Attempts were made to gain the cooperation of the patient and a brief and simple explanation of the treatment was given immediately before the induction. As

might be expected, this was not well received by the patients in this group until after the first or second interview under narcosis. In the technique used, sodium amytal, one gram to 20 cc of water was given intravenously, at the rate of one cc per minute, until the patient reached the level of corneal anesthesia. During this induction period, no attempt was made to question or examine the patient, though any spontaneous comments or questions were discussed briefly as they came up. When corneal anesthesia had been attained, the patient was permitted to remain at this level for about 15 minutes. He was next given pitotoxin in a solution of one milligram per cc. This was given intravenously at approximately one cc per minute until the patient could be aroused without much difficulty. At this time the neurological examination was repeated and after the disability had been evaluated, the interview was conducted in the usual fashion.

By this method it was possible to evaluate the disability with considerably less difficulty than we had experienced under the ordinary neuropsychiatric approach. The residuals of the injury could be differentiated from the conversion symptoms and from the conscious distortions. Repeated neurologic examinations were no longer necessary and the examiner usually did not convey to the patient any of his own doubts concerning the origin of the disability. With this prompt clarification of the diagnostic confusion, psychotherapy could be instituted at once. The lessening of the resentment and hostility so frequently encountered in these patients is certainly not one of the minor advantages of this type of approach. With repetition of the amytal interview, it was possible to facilitate the therapy and a considerable saving in time consumed was effected. This is a factor not to be overlooked in an Army General Hospital.

SUMMARY

It has been our experience on an N.P. consultation service in a named general hospital, that the cause of a manifest disability is oftentimes difficult to evaluate by ordinary clinical examination. With the aid of deep narcosis we have been able to determine that the disabling symptoms in some of these cases are functional in origin rather than the residual of the original injury. Having made the diagnosis of hysteria by this method, psychotherapy can be initiated at once. By means of deep narcosis the initial hostility not infrequently encountered in cases of this type by the usual psychiatric approach, can be eliminated or materially reduced. The use of intravenous sodium amytal is recommended because the deeper levels of narcosis required in these cases can be safely produced and easily controlled.

DEEP MENTAL NARCOSIS IN THE DIAGNOSIS OF HYSTERIA

Discussion by Clarence A. Neymann, M.D., Associate Professor of Psychiatry, Northwestern University.

The paper by Major Meister and Capt. Conrad is very timely. It is patent that we may expect to encounter numerous special psychogenic conflicts and tensions in the injured and convalescent veteran. Usually these do not occur in civilian life. In a way we might state that almost any veteran, who has been injured, especially if the injury is extensive and looks as if it were permanently disabling, has a tendency towards invalidism.

In the first place, the veteran questions whether he will not be seriously disabled in later years after he has been discharged. Secondly, he has become accustomed to army life and to all the fine generous care which is heaped on him. Thirdly, he considers himself a hero and wishes everybody to realize that he has fought and suffered for his country. Fourthly, he may be escaping from difficult family situations, which do not trouble or frustrate him while he is in the hospital. Fifthly, he knows full well that the greater the disability the more extensive will be the reward in the form of a pension. Finally, he may simply have become lazy during his life of luxurious ease.

It is, therefore, clear why any veteran should be antagonistic to a psychiatrist, who is at best a kind of witch-doctor, likely to upset his comfortable and complacent flight from reality and at worst a mean fellow, who may call him insane or peculiar and bizarre. No one is desirous of having his mental aptitudes questioned.

For these reasons, which are really nothing more than an interreaction between ego, id and superego, deep therapeutic narcosis would seem to be indicated in all cases where the diagnosis is in doubt. During narcosis the higher integrative judgment of the ego is temporarily lost or in abeyance. Therefore, the patient will be much more easily persuaded to cooperate with the examination; especially when he is asked to move muscle groups that are functionally paralyzed. In a way, deep narcosis is equivalent to the lack of finer judgment seen in acute alcoholism.

Temporarily the patient becomes therapeutically accessible. Only a very deep narcosis can be expected to influence such patients. They will discharge their tensions only when their ego judgment is in abeyance. However, we must remember that the final cure will depend on an explanation at a conscious level. The whole problem must be approached by strengthening the ego and weakening the id and subconscious superego desires and conflicts.

We must also bear in mind that a great number of these psychogenic casualties cannot and will not be helped because the surcease of remaining ill may overshadow all arguments the psychiatrist is able to muster. Everyone is more or less egocentric and selfish. In the vast majority of these cases the psychiatrist

stands squarely arraigned against the present conscious pleasure principle.

Painstaking investigation frequently discloses that the veteran was neurotic long before he entered the army. At the Veterans Rehabilitation Center, Chicago, Illinois a number of patients have been observed who were quite brave, active, and reliable during conflict, but became war casualties as soon as the campaign ceased, or when their missions were over, or after they were discharged. Such patients attain their need of subconscious punishment while their life is in danger. Deep narcosis may bring their tensions to light, but as before stated the final treatment depends on disclosing the facts at a conscious level. Manifestly, this is impossible in a patient of low mentality or in one whose resistance is too great.

THE PSYCHOPATH IN THE U.S. ARMY

Leo A. Kaplan, Captain, MC*

An unusual amount of literature has been published relative to psychiatric problems since the onset of the war, particularly dealing with mental hygiene setups in reception and training centers; recognition of psychoneurosis in induction stations and combat theaters; various methods used in treatment of combat fatigue and so-called combat neurosis, but, probably because of the hopelessness and complexity of the problem, very little has been said with regard to the behavior disorders. It's importance is known to all of us practicing psychiatry in civilian life, as well as in the army. The errors that were made from induction and through the period of army training were not primarily due to the army psychiatrist's inability to recognize the problem or in the proper management, but rather to the lack of cooperation in other departments in the army's large organization. Along with this was the constant pressure exerted on the army by political organizations as well as the general public. These same behavior problems are again being thrown upon society only in greater number and during a period of economic crisis.

Unfortunately most of the individuals discharged, because of both minor and major behavior disorders, will be covered by the G.I. Bill of Rights. One has only to read the daily papers to see the already increasing number of crimes committed by discharged veterans. In the Cook County Behavior Clinic where detailed social histories are taken, most of the cases indicate asocial and anti-social behavior both before and during army career. Well meaning Veteran Organizations intercede in behalf of the veteran and as a result, unwittingly, interfere with proper judgment of disposition. The greater percentage of these individuals are recidivists and in due time will again be displaying their psychopathic tendencies.

I refer, particularly, to the primary behavior disorders including simple adult maladjustment, mental defectives, chronic alcoholics, and the constitutional psychopaths. The latter have long been a challenge to psychiatrists, law enforcing agencies, and society in general. We, as psychiatrists, have long recognized the almost hopeless and ever increasing burden these individuals place upon themselves, their families, and society in general and the responsibility for initiating action is ours.

I had, fortunately or possibly unfortunately, been in a position to study these individuals over a period of fourteen months in an A.S.F. Training Center. This was only a continuation of my former experiences with similar types of individuals in civilian life at the Cook County Psychopathic Hospital, Cook County Jail and the House of Correction. In the service, I also had the opportunity to speak with ranking line officers and psychiatrists, returned from overseas, with regard to the same problem. Their experiences add further confirmation to my remarks which follow.

To better understand why there was such an apparently large group of behavior problems at this particular post, one must consider the overall picture of army classification and assignment. It is generally known that

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certain branches of the armed forces have preference in selection of personnel. The Navy, Army Air Force, Army Ground Forces, as well as other branches have had first choice in the selection of the physically and mentally superior men. The remainder found their way to the A.S.F and as a result of this gravitation, there became a stagnation of certain personality types. This led to decrease in morale, as there was dissatisfaction, discontent, loss of esprit de corps which ultimately allowed for release of formerly controlled behavioristic disorders. Special training units were set up by the army to assist illiterates as well as a certain number of mental defectives who were inducted. Many of the latter group were rejected at the Chicago Induction Station at one time, but I guess, subsequently re-examined and inducted with the pressing need for manpower. Unfortunately, I am in no position to determine what percentage of the borderline individuals made successful soldiers, as I only saw those that were failures. From what I have seen, apparently few of the induction stations throughout the country continuously maintained the high standard of requirements to qualify for the service.

At induction, psychiatrists especially were called upon to be alert to detect and reject selectees exhibiting evidence of mental deficiency and pre and post psychotic personalities, the psychotic, constitutional psychopaths, and other individuals who later may disrupt discipline and morale, occupy hospital beds needed for acute cases, and finally becoming an economic burden to the government. As the cry for manpower became more urgent, less discretion was used in accepting men for military service. It is generally known that not all types of individuals are adaptable to restrictions and inhibitions of personal desires and conforts, nor to deprivation of rest, food, shelter, and as often times arises, extraordinary demands for prolonged physical and mental activity. Many individuals of abnormal personality makeup who are capable of satisfactory adult adjustment in civilian life, where there are numerous avenues of escape, will be at a total loss to adjust to an inflexible and circumscribed pattern as exists in the regimentation of army life. When thrown on their own resources of adaptation, meagre as it may be, these individuals do not fit into the inelastic mold that the army demands. These individuals begin to show manifestations of their inadaptability by becoming sulky, discontented, lonesome, depressed and suspicious. Some become overboisterous, gregarious, obstreperous, resentful to discipline, and ultimately totally useless for further military service. With continual demands made upon them, some resort to chronic absenteeism (AWOL), others regress to either newly formed or previously existent excessive drinking habits, and still others may develop full blown neurosis or even psychosis. It is not to be forgotten that when the more serious mental disorders develop they are frequently designated as in line of duty, thus not only does the individual become a total loss to himself, family and community, but an economic burden to the government usually for the remainder of his life. It is estimated that each casualty, from the last war, cost the government approximately $30,000 and this is only a minor factor in the overall picture. The soldier discharged because of a behavior disorder is equally entitled to all the rights and privileges of the G.I. Bill, as the soldier who faced danger of combat and those physically and mentally ill.

The psychopaths as we know them in civilian life, more or less retain their same behavior pattern in the army and as a group, are incapable of attaining satisfactory adjustment. These individuals were not capable of adjusting to the minor demands placed upon them by society in civilian life, so one could hardly expect they would do better under more restriction, inhibitions, and self-sacrifice. They are emotionally unstable, undependable, act impulsively, are erratic in their behavior, show poor judgment, are always in difficulty, and attempt to get others into difficulty. They are non-conformists, resent authority, and attempt to cultivate insubordination in others. Their past histories in civilian life, frequently reveal broken home situations, juvenile delinquency, truancy, nomadism, criminal propensities, periodic inebriety, drug addiction, paranoid tendencies and sexual psychopathy. The largest percentage of our chronic absenteeism and desertions are found to be individuals who can be called psychopaths. It has become very apparent that all efforts at rehabilitation of this group are unsuccessful. Rehabilitation camps have had only a fair degree of success with individuals who were recidivists but whose past personal history was free from psychopathic tendencies. The recidivist in the army with a past history of asocial or antisocial behavior was almost always hopeless for possible restoration to duty.

Another group receiving very little attention in the literature are the malingerers. The few articles published recently tend to indicate a low percentage but of course, that depends upon what one considers malingering. In the military service, it is almost impossible to convict a soldier of malingering by general court martial as the element of wilful intent is difficult to prove. Many individuals with physical conditions, exaggerate their complaints with a consciously impelled ulterior motive. Although this could be construed in the true sense of the word as malingering the tendency is to overlook it and explain the behavior as emotional maladjustment or inadaptability. When pressure to perform duty is enforced on these individuals, various types of reactions become evident. The greater percentage become resentful, resistive, and refractory to discipline, Morale becomes low, sense of responsibility, pride, patriotism and efficiency of the soldier is lost. More important than his loss to the army is the pattern of behavior which becomes well ingrained in the individual and the effect it will have upon his adjustment emotionally, socially, and economically in the future. One could well argue the point as to whether or not these individuals could be looked upon as malingerers or basically emotionally immature, unstable, inadaptable individuals. The Russian literature is meagre regarding these individuals, with frank statements that one does not see malingering. Again we must remember, the Russians had a different philosophy in life, a different political ideology, and strong hatred for the enemy, as only those individuals could develop who had their homes, families and country ravaged by the enemies.

It is the general consensus of opinion that the majority of guardhouse prisoners, i.e. the psychopaths, alcoholics, and other mentally ill persons, should never have been inducted into the military service. On the other hand, rejecting these individuals or returning them to civilian life would obviously create resentment and poor morale in the soldier who was conscientious and willing to make sacrifices. The mentally and physically adequate youth of the nation became invalids by the hundreds of thousands, whereas remaining behind were the psychopaths, alcoholics, etc., who will

continue to display their asocial and antisocial behavior, and become economic burdens to society and financial drains on the government.

Mira, former Psychiatrist in Chief of the Spanish Republican Army, claimed that he achieved good results by transferring most of the delinquents to the disciplinary and labor brigades, which were called upon to either perform heavy work or asked to provide volunteers for especially dangerous tasks. I wonder what he considered, "good results".

In my own personal opinion, I feel we have erred in judgment by not considering a fundamental proverbial saying, "Survival of the fittest". Our great problem, post war is now the same old question, - only ever increased, - "What to do with the Psychopath?"

DISCUSSION

Dr. John J. Madden*

Dr. Kaplan is to be congratulated on his forceful exposition of a serious psychiatric and social problem. To those of us who are connected with institutions which admit large numbers of individuals exhibiting behavior deviations, the high incidence of constitutional psychopathy has always caused deep concern. Since these individuals are usually of good intelligence and shrewdly sophisticate in demeanor, their serious personality disorder may remain undiscovered for long periods. Acutely aware of the ease with which maudlin sympathy may be aroused they impose upon well intentioned but naive lay people, and occasionally psychiatrists, and as a result they go on their merry antisocial way leaving turmoil and chaos in their wake.

One hears endless discussions concerning plans for the better care of the neurotic and psychotic but seldom is mention made concerning plans for more adequate and efficient care of the psychopath. Currently and for several years past much investigation goes on and much is written regarding alcoholism, but only occasionally is it recognized that in the goodly percentage of so-called chronic alcoholics the basic disorder is constitutional psychopathy.

Treatment is as we all know, eminently unsatisfactory. However, there is at least a possibility that a more general and forthright recognition of the problem and its social implications may lead to more efficient methods of care.

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PSYCHIATRIC PREVIEWS

Lt. Col. Paul A. Petree, MC*
Capt. Lawrence K. Taylor, MC*
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The progress of psychiatry has been somewhat cyclic, almost seasonal, coincident to the regularity with which wars occur. In peacetime the progress has been at pedestrian pace compared with the tempo set by war; for war works fast and kicks hard and opens the gates to many ideas that may be today's psychiatric previews of tomorrow's procedures.

The mass of clinical material made available by the war permits statisticians to card-index disorders, symptoms, etiological factors and personality types, so that by a punch system, or a code system, similar in manner to matching fingerprints, almost any information is made immediately available to the investigator.

The high incidence of neuropsychiatric disorders that has occurred in the military forces has resulted in much criticism from both lay and professional sources of the screening processes at our induction centers. While thousands of the emotionally and physically unfit were weeded out, other thousands slipped through the net. Much of this criticism has been unwarranted. It has been revealed that not only the individual with inherent physical and mental weakness becomes a psychiatric casualty, any of us--you and you and I--has his breaking point under a given chain of circumstances: disease, exhaustion, prolonged combat, economic distress or domestic discord. Many of the neuropsychiatric casualties admitted to Army general hospitals have as good a background from a physical, educational, social and economic standpoint, as can be elicited from any of us who have not yet succumbed. It is likely that the inductee screened for the next war will be given a probationary training period during which the psychiatrist, psychologist, psychiatric social worker and chaplain will work along with the line officers in an effort to further eliminate potential psychiatric casualties. This procedure has had an experimental try-out in the Women's Marine Reserve Corps.

The war has stimulated ideas and much knowledge has been gained in both the field of mental hygiene and in the management of psychiatric problems. For instance, it is believed that intra-psychic phenomena and unconscious childhood conflicts have been over-stressed in the development of neuropsychiatric disorders. Rigid Army regulations, separation from home and the hazards of war breed insecurity and permit minor personal problems to assume tremendous importance. More emphasis should be given to the conscious conflicts, physical defects, and to obvious environmental and situational determinants.

Evidence that there is very close relationship between these precipitating causes and nervous disorders is convincing

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when it is observed that many soldiers recover from their battle reactions when removed from combat. Many recover on board ship returning home, while others recover in the hospital after two or three reassuring visits from their family. Those soldiers who develop disorders as a result of economic, social or physical conditions recover when bad assignments are corrected or the soldier is permitted a furlough to straighten out some financial or domestic difficulty, or when the physical defect is cured.

The writers do not believe that every soldier who exhibits introspection, moodiness, irritability, or even violence toward his superiors because of some of these problems, is necessarily showing evidence of a psychoneurosis. In certain instances this reaction is normal to the situation and we believe that in the Army, even as in civilian life, most soldiers should be allowed to express righteous anger toward their superiors.

In view of this knowledge it is certain that university professors, teachers and investigators will, of necessity, give less space in their text books to the major psychoses, and more time, attention and energy to the cause, prevention and management of the psychoneuroses and psychosomatic disorders which constitute the major factor in the loss of manpower.

In this war we have seen relatively fewer cases of schizophrenia and manic depressive psychoses, and more cases of unclassified psychoses than is seen in the civilian population, but by large odds the majority of the cases have been psychoneurotics of one type or another. The severe type may resemble an acute psychotic episode. In the civilian the causes are subtle and diverse; in the soldier they are objective or situational, and his conflicts are more immediate and more conscious. There is closer relationship between cause and effect. The soldier's reaction is abrupt in onset, severe in degree and shorter in duration, and becomes similar to the civilian's illness only when his war reaction merges with pre-existing neuropsychiatric components and with recovery he tends to retain only those pre-existing abnormalities he harbored as a civilian.

There is yet to be developed an accepted diagnostic laboratory test for functional mental disorders. Some advancement has been made in psychology, in personality studies, psychometry and aptitude testing. The Rorschach and other tests have been popularized, but the final diagnosis is still a clinical one.

This war has made the public acutely conscious of nervous and mental diseases. The profession must be able to cope with the problems that industry, labor and the individual will present. Our industries will require the services of trained personnel who will see that the employee is placed in the job he likes and is competent to perform, and that he is properly compensated. This will safeguard the morale factor, as essential to the civilian as to the soldier, and promote emotional security necessary to maintain a high level of efficiency in his work.

The demand for neuropsychiatric personnel is going to be very great. The Army has had to take a positive stand to cope with this shortage and has had to introduce a large number of young medical officers into the field of neuropsychiatry. While the Army recognizes that these men are not trained psychiatrists, nevertheless, we feel it has been beneficial in stimulating interest and in making a large number of men conscious of the importance of neuropsychiatric disorders. This has been reflected by more neuropsychiatric referrals and consultation requests.

To compensate for the shortage of personnel, the Army general hospital has developed a psychiatrist-psychologist-social worker team which has proved highly efficient and most useful in producing the fullest possible clinical picture and in carrying out group psychotherapy and other treatment procedures. Such a team is strongly recommended for after war needs. Centers devoted to the rehabilitation of veterans have already seized upon this team idea.

Since in this war there has been no outstanding development in management and treatment, the blueprint to be followed is the continued use of those procedures of the past which are thought to be worthwhile. This calls for well-trained and understanding personnel with proper attitude and technique. The psychiatrist and medical officer will collaborate to obtain a sound physiologically functioning body. Our veterans and state hospitals should freely utilize the services of a consulting staff. Individual and group psychotherapy, occupational and recreational programs, and hydro- and physiotherapy; all play an important part.

It is essential that not only the soldier, but any mental patient should be hospitalized according to his social, economic and intellectual level; that is, the intellectual should not be hospitalized with a defective, nor should the man with a high moral sense be placed with a moral degenerate. Each patient should be seen promptly on admission and oriented as to the reason for his admission and it is wise to discuss briefly with him the interrelationship between physiological and psychological processes so that he will have a better concept and be able to interpret body sensations, such as palpitation, sweating and tremors occurring in anxiety states, that might otherwise frighten him and result in introspection, self-criticism, or withdrawal manifestations. He should be told what his privileges and restrictions will be. It has been found that soldiers received in convoys tend to band together, which aids them in adjusting to their new situation. This morale factor is followed up, and wherever possible in transferring patients from one ward to another the group idea is maintained.

The management should provide for progressive steps. If a disturbed patient quiets down, he should be moved from a closed to an open ward, and if there is further improvement, additional privileges should be extended. We often observe pronounced im-

provement simply in moving a patient from a locked to an open ward. Later, passes and furloughs should be added. This restores his confidence and provides him with an incentive to get well. In doubtful cases, the patient should be allowed to go home on visits several times before he is discharged. Many have to be re-inoculated or desensitized to their homes or civilian life. The idea of sending patients to the country to be "close to nature" has not been sufficient. What the patient really needs is a good job to restore confidence and self-respect.

There should be close working relationship between our mental hygiene clinics and industry. It is our opinion that these clinics could carry along many veterans and other persons in groups on an out-patient basis with weekly interviews and thus avoid hospitalization with a consequent loss of manpower. In this manner, many illnesses would receive early treatment which otherwise would progress to the stage of chronicity.

Along with the procedures outlined above, special treatments will be given. There has been a revival of interest in the use of insulin. At Vaughan General Hospital we provide music during the insulin treatments. Many patients, such as the anxiety cases, to whom one would hesitate to give insulin on a deep coma level have been carried on a sub-shock level and many stubborn cases have received insulin coma alternating with electric convulsive therapy. The insulin is given once a day intravenously, gradually bringing up the dose to the desired effect and then gradually decreasing it. Electric shock is limited to a small group of patients. Group psychotherapy has proved valuable and helped to solve the shortage of personnel. Hypnosis and narcosis have been popularized. We have used hypnosis to suggest away symptoms or attitudes underlying symptoms, to obtain repressed material, and for abreaction. We have used pentothal and amytal as a sedative, to establish better rapport, to obtain information, and to facilitate the handling of resistive patients. After its use many patients will participate in ward activities or go for walks, while others who had to be tubed or force fed, will eat.

The effectiveness of these various procedures in an Army general hospital, taking only the psychotics and severe psychoneurotics, can be somewhat evaluated from the following figures: From 1400 admissions there have been 1125 dispositions. Of these 700 received insulin and 100 electric shock. Only 145 have been sent to veterans' facilities for further care. In another general hospital treating all classes of neuropsychiatric disorders, from 1800 dispositions, only 85 were sent to a Veterans' Administration Facility. In other words, out of approximately 3000 dispositions only 230 have been sent to veterans' facilities.

The management of neuropsychiatric patients may also include a planned passive or negative approach. The policy is not one of "watchful waiting" or just "sitting tight and doing nothing", but is patterned somewhat after the thought expressed by a mental patient who raised canaries as a hobby. He had several trick birds that would perch on his fingers and clip his fingernails or light on his bald head and peck at his stubby hair or dandruff. One day a visitor asked him, "Oh, how did you train the bird so well?"

to which the patient replied: "I did not train it - it trained me. I just watched and found out what it wanted to do and let it do it." We may apply the same philosophy. Patients think their own thoughts and live their own lives and we can often assist them most by watching and finding out what they want to do and help them to do it.

It has been observed among the nurses and attendants, that individuals who are a bit comical or inclined to indulge in witticisms are often able to handle or manage certain patients with whom no one else could establish such good rapport. The possibility of combating one emotion with another appears to be worthy of investigation. Humor is a very powerful and therapeutic emotion. It is little studied and less is known about it. Laughter is the physiological expression of humor, and anyone with a sense of humor who can laugh or make his patients laugh will be an asset to his organization.

We have made many diagnostic examinations and tests before, during and after treatments, and have arrived at the conclusion that there are a host of factors that should be emphasized - that each method and treatment plays its own part. It is not insulin or electric shock, it is not individual or group psychotherapy, it is not the individual doctor or his particular method - it is the prompt application of all factors favoring improvement. Getting the patient started promptly on the right foot, down the right road - and it is just as difficult to separate one method from the whole as it is to separate one battle from the war.

DISCUSSION OF: PSYCHIATRIC PREVIEWS

Discussed by: David Slight, MD,
Professor of Psychiatry,
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The authors rightly say that events in war move fast and that the gates have been opened to many ideas which may lead to the development of new procedures for tomorrow. Also, they speak of the mass of clinical data that has been collected during the war which should be available to the psychiatric investigator. We can only hope that all this valuable information will be so utilized.

They comment on the high incidence of neuropsychiatric disorders in the military forces and of the ensuing criticisms of the screening processes at induction stations. We all recognize the difficulties that beset the examining physicians at the induction stations in the early part of the war. However, it is to be regretted that when information was provided under the medical survey plan of the Selective Service System, this was not always used to the best advantage in the screening processes at the induction stations. This is a sad commentary on the discussions that took place in our psychiatric societies before the war started when we reviewed the experiences of World War I in regard to the psychiatric procedures and standards that should be adopted in mobilizing for a future war. Thus, we did not benefit very much from our discussions, or at least we were slow in putting our knowledge into effective action.

I think we may fairly take issue with the authors when they talk about the possibilities of a probationary training period in a future war when the psychiatrists, psychologists and others would work to eliminate the potential psychiatric casualties. From all that we have been recently learning, it does not seem much time will be available for such special preparation. It is more likely that if any time is left for discussion or planning, we shall have something like a national service act whereby every person will have to serve irrespective of actual or potential disability.

Doctor Petree has said that many of the men discharged with neuropsychiatric diagnoses are not comparable to the neuroses of civilian life. However, he does not indicate that he differs with the majority of psychiatrists who affirm that the neuroses occurring in war are similar to those of peace time. It would seem that he means to say that many of the so-called neuropsychiatric disorders in the army were direct reactions to the particular circumstances of army life, in fact, that many of these conditions were not psychoneuroses but frank emotional reactions of moodiness, irrita-

bility, and the like. In other words, many were ordinary emotional reactions, normal in the circumstances.

The authors state that no accepted diagnostic laboratory test for functional mental disorders has been developed. I suggest that none of the tests we are permitted to use can arouse the emotional conflicts or tension situations which are part and parcel of our everyday life. It is unlikely that any adequate laboratory tests for the functional mental disorders can be developed unless we could arouse conflicts and emotional tensions beyond anything now permissible in laboratory or clinic. In any event, every patient has been subjected to many experiments of nature, and a complete clinical history is a record of responses to all sorts of situations, many of which could never be duplicated under laboratory conditions. Therefore, we should continue to cherish the value of the clinical history and examination.

It is true that the public has now become acutely conscious of nervous and mental disorders. We are also beginning to recognize the far-reaching importance of psychiatric knowledge in many aspects of human relations. We should also recognize that a large part of psychiatry is more of a social science than a biological science. Thus, the psychiatrist should be prepared to cooperate with the educator, sociologist, criminologist and others in the field of human relations since each can learn much from the other. This new consciousness will lead to the development of psychiatric, psychological and social worker teams, which have proved so highly effective in the war, as Doctor Petree has said.

The authors believe that we have not discovered very much new in psychiatry in management or treatment, and so they emphasize the necessity of making use of all available techniques that may be helpful in the treatment of the individual case. However, one development has taken place, namely, the realization by many of our colleagues of the importance of psychiatry. Dr. Karl Menninger once called psychiatry the Cinderella of the medical sciences. Cinderella is now grown-up, and many are now paying court to her -- so many, that she finds it embarrassing to cope with them all.

I was glad to hear the authors conclude with a statement emphasizing the importance of getting treatment started promptly and on the right pathway. It is about time that we put into practice some part of what has been preached in the name of mental hygiene during the last generation and all that we may have learned from our experiences in the war.

THE NEUROPSYCHIATRIC SERVICE OF THE PERCY JONES CONVALESCENT HOSPITAL

Fred F. Senerchia, Lieutenant Colonel, MC*

In describing to you the neuropsychiatric service of our Convalescent Hospital, it is perhaps wise to pause for a moment and trace the gradual evolution of the care of open ward neuropsychiatric patients in fixed installations of the Zone of the Interior.

It was not so long ago when all such patients regardless of severity of reaction, were hospitalized as ward patients of our hospitals. Early in the war as the Zone of Interior patient loads began to increase with the attendant loss of manpower and manpower hours, the necessity of establishing outpatient neuropsychiatric facilities at installations which were feeding these patients to the hospitals became apparent. Judiciously there came into being consultation services and Mental Hygiene clinics in the larger military installations. This marked the beginning of the march of psychiatry from the confines of the hospital to the field. It marked, also, the beginning of the wide spread use by psychiatrists of auxiliary services such as those rendered by clinical psychologists and psychiatric social workers. The next step was the bringing of psychiatry to the divisions by the assignment of divisional neuropsychiatrists. They not only brought mental hygiene to the field but also therapy by working in the forward areas when the division had been committed to combat. The next step, an experimental one, was the re-training of psychoneurotic casualties at three Army Service Forces Training Centers while on duty status, for new assignments in the Zone of the Interior. Eventually there came into being, the Convalescent Hospital with a section thereof devoted to the definitive care and treatment of the open ward neuropsychiatric casualty. Since the convalescent hospital offered the patient a modified type of garrison living, it marked the final emancipation of the average open ward neuropsychiatric patient from the former hospital type of ward care.

The advent of the convalescent hospital brought into focus many problems. We no longer had wards but companies and battalions. We no longer had ward masters and nurses, but first sergeants, company clerks, duty non-coms, company commanders, and battalion commanders. Since almost all of our patients came directly from overseas, it was necessary to handle these patients at as near a general hospital level as possible if professional standards of care were to be maintained. Therefore, from the beginning we made plans for the rendering of a general hospital type of professional care in a setting of barracks, companies and battalions. To more effectively accomplish this, we had to coordinate the purely administrative services with professional services, so that the two could be welded into an organizational whole and make for a smooth running unit. By borrowing from the experiences of the consultation services and mental hygiene clinics, from the experimental developmental training units set up under the provisions of ASF Cir #40 dated 5 Feb 44 and from TB Med 80, we were able to set up such an organization.

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Apart from the officer patients, the neuropsychiatric service is organized as a regiment. The regiment is quartered in an excellent area of Fort Custer. The patients are housed in newly reconverted two-storied barracks with a central heating plant and inside latrines and showers. The area has its own Post Exchange, Red Cross Recreation Building, Red Cross Professional Building, occupational therapy shops, conference rooms for orientation and group psychotherapy, athletic fields and many company day rooms.

At regimental level are found the regimental commander who is chief of the neuropsychiatric service and the regimental headquarters staff who are the coordinators for the various professional and non-professional services rendered the patients from within the regiment. It is also at this level where liaison is maintained with the auxiliary non-regimental services, such as educational and physical reconditioning, separation classification, personal affairs and the Red Cross. Briefly then, regimental headquarters consists of the commanding officer who is also chief of the neuropsychiatric service, a branch immaterial executive officer who supervises and coordinates the purely administrative functions of the regiment; a chief clinical psychologist who supervises and coordinates the psychologists of the regiment and in addition, maintains liaison with separation-classification and educational and physical reconditioning as operations officer; a chief psychiatric social worker who supervises and coordinates the work of the psychiatric social workers and maintains liaison with personal affairs and the Red Cross; and a sergeant major and clerks.

In order to bring the maximal amount of individualized professional care to the patient, the regiment was organized into five battalions of 400 beds each. Each battalion is headed by a battalion commander who functions in addition, as it's senior psychiatrist. He is the focal point of what is in reality, a self-contained psychiatric unit. He has at Battalion Headquarters level coordinators similar to those at regimental level, namely a branch immaterial executive officer, a chief psychologist and a chief social service worker. In addition, the Battalion Headquarters or psychiatric unit is staffed by the company neuropsychiatrists and social service workers, clinical psychologist, clinical records clerks, civilian medical stenographers and a sergeant major.

The battalion, in turn, is organized into four companies of 100 patients each, comparable to four one-hundred bed wards. Assigned to each company is the company neuropsychiatrist whose duties are comparable to a ward officer even to the making of ward rounds. Assisting him in the discharge of his professional duties, is the assigned company social worker and the battalion clinical psychologists. There is thus established a continuous doctor, social worker, psychologist, patient relationship from the moment the patient is admitted to his company or ward until the time the patient is dispositioned. In the diagnosis and treatment of the patient, in addition to the psychiatric team approach and individual and group psycho-therapy, the medical officer avails himself of the service of other medical and surgical specialties when the need arises. Also functioning at company level are branch immaterial company commanders, first sergeants, duty non-coms and company clerks.

The officer section had assigned to it two neuropsychiatrists in addition to a commissioned clinical psychologist. The section was housed in a professional building which it shared with the officer surgical section. The patients were under the administrative control of the commanding officer of the officer patients battalion. This section had a reconditioning program of its own.

The neuropsychiatric service from its inception saw in consultation patients referred from the medical and surgical service. This consultation service was coordinated through the office of the chief of the neuropsychiatric service.

The patients are admitted through the admission and disposition office to the receiving division of the convalescent hospital. There they are examined by a physical examination team, two members of which are neuropsychiatrists. At this level those cases felt to be too ill for convalescent hospital care are screened out and sent to the neuropsychiatric service of the Percy Jones General Hospital Annex at Fort Custer. In addition to the physical examination, histories are taken and routine laboratory work and chest X-rays are done where necessary. Following this the patients are admitted directly to one of the neuropsychiatric battalions. Here a battalion file is opened on the patient and it is at this level that the neuropsychiatric processing is done by the neuropsychiatrists, psychologists and psychiatric social workers. In addition to a mental status by the psychiatrist, a psychiatric social summary is obtained by the social worker, and an initial evaluation is made by the psychologist for placement in the educational reconditioning program or for psychometry. When this has been completed and clearance given by the psychiatrist, the patient is ready for furlough if he has come directly from a debarkation hospital. The entire processing from admission to furlough takes an average of less then five days. Upon return from furlough the patient enters the treatment program and is followed up by his company neuropsychiatrist, company social worker and clinical psychologist. During the course of his treatment the clinical record is completed and when the patient has received maximum hospital benefit, in general between 6 - 8 weeks after return from furlough, he is brought before a neuropsychiatric staff conference consisting of the battalion commander, who is the senior psychiatrist, the psychiatrist presenting the case and one other medical officer. This staff conference functions also as the disposition board. Here final diagnosis is made, line of duty is established and disposition recommended if it is felt that the patient has received maximum hospital benefit.

Neuropsychiatric Treatment Program: In a discussion of treatment for the convalescent hospital neuropsychiatric patient, in addition to the definitive individual and group psychotherapy one must include the therapeutic benefits which accrue from the ancillary services. These services include educational and physical reconditioning, occupational therapy, orientation, company commanders discussion hours, individual services, special services, the Red Cross, and the administrative services rendered by the company commanders and cadre. Passes and furloughs are considered therapy.

Every patient, unless specifically excused (usually for an intercurrent illness), is a participant in the daily program which carries on 5 days a week from 0800 until 1630. The morning program in general consists of

physical reconditioning, orientation and group psychotherapy. While the afternoon program consists of educational reconditioning (the school program) or occupational therapy, ward rounds and, weather permitting, a retreat parade once a week. Individual interviews do not follow any set schedule.

Individual Therapy: Because of the excellent facilities offered by the neuropsychiatric section of the Percy Jones General Hospital Annex at Fort Custer, all cases requiring hydrotherapy, sodium amytal or pentothal narcosynthesis, insulin therapy or closed ward care were referred to it rather than establish a special treatment section in the convalescent hospital. The more severe cases not requiring the above forms of therapy for proper management were rostered for individual therapy at the Convalescent Hospital level.

At Convalescent Hospital level, the approach was a team approach (psychiatrist, psychologist and psychiatric social worker). The individual therapy given by the non-medical members of the team was primarily along counselling lines. In general the individual therapy given by the psychiatrist was not tuned to relieving profound personality problems of long standing duration, but rather to help the soldier gain insight into the psychosomatic dynamics of his syndrome. Means were offered to ease the symptomatic discomfort by sublimation and rationalizations together with straight forward common sense psychiatric orientation.

Group Psychotherapy: Group psychotherapy was conducted for several reasons.

(1) To provide daily contact between the patient and the members of the clinical team which time limitations made impossible on an individual level.
(2) Because there was value in discussion of mutual personal problems on an impersonal group level.
(3) Group discussion made the patient realize that his problems and complaints were not unique but were shared by others.
(4) It allowed for release of aggression.
(5) It gave the clinical team an opportunity to evaluate the total program from the attitude of the group. (Observation obtained by all members of the clinical team were shared for the benefit of the total program.)

We found that one of the most difficult tasks we had was the standardization of the group psychotherapeutic program. From the beginning, the various battalions were encouraged to evolve their own programs in an endeavor to arrive at a common denominator for the regiment. The various battalion programs were then assessed at staff conferences so that eventually the following program was adopted as being most suitable from the point of view of personnel and case load.

Administration: All patients took part in group psychotherapy which was conducted by the psychiatrists, the clinical psychologists, the psychiatric social workers and through the media of selected movies. Groups were conducted on two levels; large group therapy and small group therapy.

Large group therapy was part of the regularly planned program and four one hour periods per week were scheduled. The time was divided by all the members of the clinical team. The large groups were company size (maximum 100 patients) and all patients attended large group sessions.

Due to the difficulty of handling large groups and because some patients needed more personalized therapy, small group therapy was given to selected individuals. It was found that the best therapy could be accomplished when the group consisted of 5 - 10 men, sometimes slightly larger. Patients were selected for small group therapy which was conducted by the clinical psychologist or psychiatrist in different ways. (1) Patients were referred for small group therapy by the psychiatrists and the social workers. (2) Patients were selected by the psychologist and psychiatrist on the basis of the clinical picture which made for a homogeneous group. (3) In one battalion all new patients were handled in small groups. The length of the group sessions usually varied between 45 minutes and one hour. No rigid time limit could be set. The meeting was concluded when interest lagged or restlessness was noted.

The atmosphere of the group meetings was informal. Everything possible was done to break down the traditional barrier that existed between officer and enlisted men. While the therapist had a pre-arranged plan there was no pre-arranged text for the meeting. A pre-arranged text invariably resulted in a health talk which had to be avoided. Occasional straying from the subject caused no great concern. An opportunity for release of aggression was valuable and had to be encouraged. Later in the day, Captain Hirschfeld will present to you his experiences with the technique while a member of the convalescent hospital staff.

Educational Reconditioning: Educational reconditioning was considered adjunct therapy. In order to place this activity on a doctor-patient relationship it was coordinated in our battalions through the clinical psychological sections which were under the supervision of the medical officers. As a result, our patients were given assignments by individuals who had understanding of the emotional problems involved and whose progress in the particular studio, shop or class room was followed from a psychological point of view. The school and shop program aided materially in stimulating a reawakening of interest and combating apathy which was initially present in many of our patients. It helped restore confidence in our anxietous patients, particularly those showing preoccupation, restlessness, inpaired concentration and inability to sustain attention over long periods of time by proving to them, through personal performance, that they could cope with their deficiencies. For those exhibiting startle reaction the more noisy shops permitted them to make adjustments to occupational noises.

Occupational Therapy: This was utilized for our more severe anxietous patients and those with poor intellectual endowment who were on psychiatric grounds not ready for the more formal school and shop program.

Physical Reconditioning: It was found that maximal therapeutic benefit was derived from competitive games and athletics at inter and intra company, battalion and regimental levels. This approach made for spontaneous participation and in addition to restoring physical fitness, aroused enthusiasm and a feeling of "belonging" on the part of the patient for the first time since he was lost to his unit overseas and remained lost in the hospital evacuation chain. This rebirth of enthusiasm and feeling of "belonging" made for good patient morale which was essential for effective, more formal psychotherapy.

SPECIAL PROJECTS:

Company for psychopaths: Due to the large number of psychopaths being admitted despite directives, it was imperative that something be done to prevent the undermining of morale of the other patients and sabotaging of the program by these military delinquents. At the suggestion of Major Nils B. Hersloff, M.C. a special company was activated. This type of patient was processed rapidly and returned to duty to be handled administratively by the line. In time, the company became known as the special treatment platoon to which were sent, in addition to the aggressive psychopaths, those patients who were awaiting courts martial principally for AWOL and those who were sentenced to restrictions by courts martial.

Trial Furloughs: When it became apparent that the symptomatology of a small number of patients was aggravated and accentuated by anxieties relative to civilian adjustments and rehabilitation, Major Nils B. Hersloff instituted the policy of trial furloughs. After maximum hospital benefit had been attained and prior to final disposition, this group of patients were given furloughs of from five to ten days. Inasmuch as they were definitely aware of their ultimate disposition they were enabled to establish their families, obtain employment and accustom themselves to the routine of civilian living. In some instances it was necessary to repeat these furloughs in order to dissipate the accumulated anxiety. Approximately eight percent of the patients dispositioned by Major Hersloff's board have required and requested such procedure and as a result benefited immeasurably.

Duty Company: The duty company was established at the suggestion of Captain Willard Z. Kerman after an exhaustive study in order to effect a physical separation between patients who were likely candidates for duty and those who warranted separation from the service. Mingling of duty prospects with those who should be separated from the service blocked adequate therapeutic endeavors. All duty prospects in the regiment were transferred to this duty company as soon after return from convalescent furlough as possible. At this level orientation and psychotherapy programs were conducted with a return to duty as a key note as opposed to adjustment to civilian life.

This company was of necessity created since the policy of higher authority prevented the medical officers from informing the patient of his ultimate disposition. However, shortly after its establishment this policy was relaxed and the company disbanded.

In a staff evaluation of the program we are unanimously of the opinion that the majority of patients whom we have returned to civilian life have been adjusted to the point where once again they can take their places in the community as useful citizens. There is no single factor responsible for this. The professional approach used, utilizing the psychiatrist, psychologist and psychiatric social worker as a team was in no small way responsible for the results achieved. While everything done for the patient constituted treatment including company management, the contributions of the professional team in terms of group and individual psychotherapy were the backbone of the treatment program. The therapeutic contributions made in the form of educational and physical reconditioning by the reconditioning service were very important adjuncts. We were very fortunate in having at our disposal an unusually fine educational system.

The shops, classrooms and studios were well equipped and excellently staffed. The agricultural school and its farm was an outstanding project. For the physical reconditioning program we had more than our share of playfields and recreational areas. With the coming of winter there are bowling alleys, new gymnasiums and an indoor swimming pool.

The atmosphere of the convalescent hospital provided an effective framework for the treatment program. The usual hospital ward routine was lacking and in its place was substituted a modified type of garrison living. While it is true that discipline was maintained yet our patients were given considerable freedom. The patient was free to do as he wished after five o'clock and could get week-end passes for the asking providing there had been no breach of discipline. They were in a sense on their own again; and for many of the patients this was so for the first time in many months. The self imagined stigma of an N.P. ward, even though an open one, had been removed. This simple fact was of untold therapeutic value in that it gave support to damaged egos and restored self esteem and self confidence. Most of our patients lived within a distance of 200 - 300 miles of the hospital, and consequently most of them spent their week-ends at home. As a result many civilian problems surfaced during this period. Fortunately, since the patient was still under military control, he had available the help of his doctor, psychologist and social worker, who as a team helped him resolve his newly acquired anxieties. This benefited not only the soldier returning to duty, but also the one to be discharged. The later in essence was being prepared for a return to civilian life. His exposure to it was gradual and controlled rather than abruptly from hospital ward to civilian status.

With this approach we felt that a majority of the patients discharged needed no particular follow-up in the community. Most of the patients in this group had made plans for the future and many had already secured employment by the time they were ready to be discharged. A small percentage were found however, who although they had received maximum hospital benefit, could profit from further psychiatric follow-up. Upon discharge these were referred directly by their doctor or through the Red Cross follow-up service to psychiatric clinics in or near their communities.

We of the Convalescent Hospital staff have always been extremely enthusiastic about the program and its effect on our patients. Since we have no follow-ups, our assesment of the program is based entirely on prognostication by the staff and may for that reason be biased. Be that as it may, we are convinced that the approach used was psychiatrically sound. We shall go one step further and state that for the milder neuropsychiatric casualty, the management of choice is at a convalescent hospital level.

DISCUSSION

"NEUROPSYCHIATRIC TREATMENT AT A CONVALESCENT HOSPITAL"
by
Dr. Raymond F. Waggoner*

That there would be a psychiatric problem of consequence in military service was recognized before Selective Service was established.

Early attempts were made by Selective Service to screen registrants for actual or potential neuropsychiatric disease. First at Local Board Level and later at the Induction Station, the examiners were handicapped by lack of information about the registrant. This situation was improved in 1943 with the development of the Medical Survey Plan by Selective Service and by the use of questionnaires at the Induction Station. It is believed that each development was a step forward. In spite of all screening an unfortunately large number of men were inducted who carried in themselves the potentiality of some type of neuropsychiatric disorder. Many men in service were subjected to a degree of stress which would result in neuropsychiatric symptoms in even those with high threshold values of resistance to the development of such manifestations. It is common knowledge that large numbers of neuropsychiatric casualties have developed in service. Many have been adequately treated before discharge and, of course, there have been some recurrences. Others unfortunately have been discharged too soon before the maximum degree of recovery has occurred. These men are now in the communities and are the responsibility of the Veterans Administration or civilian agencies. The problem they present is not for discussion at this time except that the problem thus presented is in more or less direct ratio to the quality and thoroughness of the treatment these men receive before discharge from the service.

Any plan which mobilizes to the fullest extent the individual's capacity for adjustment is destined to be the most successful. Such a plan appears to be the goal toward which Colonel Senerchia and his co-workers are striving. They have made an important contribution toward the optimum in treatment values.

In the first place the organizational plan has resulted in a teamwork which is a pleasure to observe. There appears to be excellent cooperation between the administrative level, the professional staff and the ancillary workers. The treatment program utilizing as it does both group and individual psychotherapy as well as important correlated activities serves not only to aid in the resolution of the patient's problem but also to keep him sufficiently occupied to prevent time lag.

Doctor Weisenburg who had a somewhat similar program at Plattsburg following World War I made a point of keeping a few patients in each ward about to be discharged, who had recovered. This kept alive a tradition of recovery which served as excellent suggestive therapy for the new arrivals. In this connection it would seem unwise to keep a patient in one installation for too long a period of time since this may result in a lowering of morale. Exceptions may be necessary but provision for such exceptions can easily be made.

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Of particular importance in the convalescent program is the opportunity for the patient to return home for one or two trial periods of a few days each, thus giving him a chance to make his civilian adjustment slowly and with a sense of security, since he knows he can depend upon those with whom he has established rapport until he can completely accept the responsibility of the civilian environment. As Colonel Senerchia points out, civilian problems may surface during such trial periods while the patient is still under military control and he may thus receive the additional help he needs before final discharge.

The psychopath always presents a serious problem in any treatment program. The sooner he is eliminated from a group such as this, the less damage he will do. I must confess that I am very pessimistic about treatment benefit in such cases. The plan of a special company would seem to be an admirable solution for this problem.

Colonel Senerchia and his co-workers are to be congratulated upon the program which they have developed. It is hoped that similar treatment procedures will be established throughout the country.

COMBAT NEUROSES IN FLYING PERSONNEL
(Abstract)

BY
ROY R. GRINKER, M. D. *

There is little difference between war neuroses in flying and ground personnel except that in the former the syndromes are milder and are colored by the special characteristics of the combat group. We have learned a great deal about the human personality and its reactions to stress by our war experiences. This knowledge is invaluable for the field of psychiatry since there is no essential difference between neuroses of civilian life and the war neuroses. Overseas the external stress looms large as the main cause of the psychological difficulties and the entire symptomatology is often referred to the stress of battle. Some psychiatrists attributed all difficulties in adjustment to pre-combat neurotic weakness and hence had a pessimistic attitude toward possible therapy. Actually there occured an interaction between the basic personality and a particular type of stimulus so that anyone could develop a neurosis. The important factors were the severity and meaningfulness of the stress. In the Air Forces the closely knit groups provided a repetition of the family situation and stimulated old unsolved ambivalences toward sibling rivals and father figures. As a result Air Force casualities showed greater numbers of guilt-pervaded clinical syndromes. We have seen neuroses originating after return from overseas, not as delayed reactions, but as new frustrations were encountered by psychologically regressed personalities. Some were psychotic-like, others were dependent to extreme, manifested by alcoholism, childish behavior and psychosomatic gastrointestinal disturbances, some showed evidences of overt aggressiveness while others were depressed. Each man's problems are individual and are not understandable except by individual investigation. The severity of the illness is not a handicap to complete recovery. Active therapy to be successful must uncover the basic conflict but equally important is the prevention of new neuroses in regressed individuals during their attempts at restitution by sensible measures to insure opportunities for new economic, social and political independence.

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FUNCTIONAL OVERLAY IN PHYSICAL DISEASE

Willard Z. Kerman, Captain, Medical Corps*

Discussing functional overlay before an audience of neuropsychicatrists entails the misapplication of a preacher's belaboring his faithful congregation for the sins of those who are absent, because functional overlay is primarily the concern of those who deal with physical disease, and only by heritage, that of the psychiatrist. We've defined functional overlay as "non-organic exaggeration, prolongation, or embellishment of physical symptoms." This paper summarizes impressions of a "psychiatrist without a psychiatric service" in a 2000-bed Army general hospital, specializing in neurology, neurosurgery, and vascular medicine and surgery, with a heavy sprinkling of general medical, dermatologic, and orthopedic problems. In approximately a thousand consultations, most cases were typical medical and surgical problems which might have been, and, in parrallel cases, often were managed sans benefit of psychiatric opinion. Thus, this represents a psychiatric evaluation of primarily non-psyohiatric problems, in a totally non-psyohiatric setting.

Functional disability is usually first suspected when the symptomatology fails quantitatively or qualitatively to match objective findings or the diagnostic requisites of an organic disorder. Though this is "diagnosis by exclusion," and hence, generally deplored, it is pragmatic and deserves mention. We have noted several characteristics, common to patients with functional disabilities, which have helped in their identification. They are:(1) A patient's lack of explanation for, or curiosity about his illness; (2) Manipulating a complaint as an argumentative foil rather than as an expession of distress; (3) An inferred challenge which says, in effect, "What are you going to do about my complaint?" instead of "How much can I do for, or in spite of my symptoms?"; (4) Failure of overt distress to measure alleged discomfort; (5) Passive indifference to prolonged hospitalization and leveling of progress; (6) Suggestibility. Any symptom mentioned is grasped by the patient. (For example, almost no patient with any functional disorder will deny headaches, if asked.) (7) Invalid leanings--spending much time in bed, though ambulatory, and wearing pajamas and bathrobe when convalescent suits are available. (8) Little socialization, or inclination to spend leisure gainfully or pleasurably. (9) Little or no planning for the future, regardless of family responsibilities.

The diagnosis of functional disability is clinched, psychodynamically, when it can be shown that suspect somatic symptoms compensate or neutralize existent emotional cravings and/or frustrations. In functional overlay involving loss of motor power, sensation, or memory, examination under hypnosis or amytal narcosis proved an invaluable aid for diagnosis and,

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treatment, as well as an effective weapon for proselytizing the skeptical organicist.

Discussion of the prevention of functional overlay involves a somewhat philosophic digression. It was demonstrated in case after case that much functional overlay was iatrogenic in origin, i.e. the product of medical management. This strongly indicated the need for a new therapeutic orientation based on more than lip service to the proposition that is is the patient, and not the illness, who must be treated. Many busy clinicians admit that half their practice is comprised of functional disorders, and yet, because it's mumbled "no one ever dies of psychoneurosis", treatment is conducted with the functional problem, a last consideration. I submit that this perspective is completely erroneous. The total of human beings needlessly functioning below their intrinsic potential, with emotionally induced incapacities blighting their own happiness and casting a pall on the rest of society, comprises far greater tragedy than any summation of misfortunes resulting from the misidentification of physical illness. I am reminded of a pathologist who delights in retelling about four men who died of hepatitis when earlier labled "psychoneurotic". He never could gain that more valid perspective that emphasized the thousands of individuals who'd been permitted, yes, encouraged, to jell into half-cripples by the injudicious management of functional headaches, backaches, tachycardias, etc.

Granting the immensity of this problem, wherein does the physician stand indicted for contributing to the development of functional overlay? In our experience the following were important: (1) Excruciatingly meticulous, diagnostic probing, beyond reasonable need. To the patient, every additional technical procedure further crystallizes his conviction of serious illness. (Particularly in patients suspected of manifesting functional overlay, or exhibiting suggestibility and dependent traits, all necessary diagnostic procedures should be prefaced by explanation and reassurance, designed to neutralize the subtle toxin implicit in their administration.) (2) "Hemming and hawing" before the patient. (Clinical indecision should be confined to the privacy of one's own mental processes. The patient may know nothing of medicine, but he instantly recognizes lack of conviction in the physician, and is harmed by the discovery.) (3) Slyly "acknowledging" the presence of a "touch" of this or that, when nothing was found. The patient remembers the diagnosis, forgets the word "touch". The utilization of diagnostic terms that "sound" like labels of physical disease, such as "cardiac neurosis" and "neurocirculatory aesthenia" when the condition is regarded as functional is a sin of the same genus. (4) Heat lamps, injections, backstrappings, and braces, naively proffered as "psychotherapy". The physician must sometime use placebos as a measure of expediency, but should not forget their true purpose. Such therapeutic gestures may fixate somatic complaints --hardly the goal of real psychotherapy. (5) Exaggeration and dramatization of the illness and the cure by self-aggrandizing physicians, recollections of "similar cases", and recitations of morbidity and mortality figures in front of the patient.

(It goes without saying that the only discussion, bearing prognostic implications, permissable within ear-shot of the patient is that which is convincingly reassuring.)

It must be emphasized again and again that the treatment of functional overlay in physical disease begins, prophylactically, the moment the patient submits to medical care. Those who are ambulatory should be kept out of bed. An extra week of bed rest can hurt. Patients with necessarily prolonged disability must be prodded to maximal utilization of their intellectual faculties, mechanical skills, and social affinities. The orthopedist has learned through sad experience, in cases of prolonged immobilization, that it is necessary to bivalve casts and apply physiotherapy in order to preserve muscle and joint function, but he and other physicians often neglect the "tone of the psyche", which must be guarded even more jealously against the ubiquitous threats of the sick room. It is not just the "eight ball" who slumps into prolongation and exaggeration of his illness. The most productive individuals have latent dependent cravings which crystalize into invalidism, if encouraged by unwarranted coddling and undue procrastination. If this occurs, even though by default, the physician has done the patient, as well as society, an irreparable damage. Let me phrase this metaphorically, " a good therapist encourages with a tug on the nose as well as a pat on the back".

Even the active treatment of functional overlay must remain chiefly the responsibility of the physician who manages the physical illness. This is necessitated by the nature of the disorder, the patient being unable to distinguish what is functional from what is organic in his symptoms. Since he has been treated for physical illness, all prodding toward maximum activity must come from the "healer" in whom he has already placed trust. In cases where emotional conflicts require the attention of the psychiatrist, management had best be a "combined operation", exercising meticulous care that avoids precipitous relegation (in the patient's eyes) to the role of "psycho". Expeditious management, dogmatic reassurance, and prodding are keystones in both the prevention and treatment of functional overlay and are psychotherapeutic measures just as truly as the more classical techniques of ventilation, orientation, and neutralization. The success of these non-specific measures negates neither the existence of a psychodynamic substratum nor the probability that some psychologic adjustment has taken place; it simply infers that the psychogenic factors were themselves relatively non-specific and superficial.

Before mentioning hypnosis and narcotherapy, it should be emphasized that many functional losses respond to patient, dogmatically insistent reassurance. Particularly is this true in the highly suggestible patient. Hypnotherapy should be an ideal therapeutic agent, especially because of the sustained effect possible in the post-hypnotic phenomenon, but its efficiency is dependent upon the skill of the hypnotist and hence, we can attest, wasn't universally successful. Narcotherapy suffers from the amnesia attendant to its administration and thus makes difficult, postnarcotic suggestion, but it proved

excellent for diagnostic purposes. To enhance its therapeutic possibilities we added picrotoxin to the procedure and are intruding a detailed description of the technique employed:

Patients were narcotized with intravenous sodium amytal. We used twice the dilution recommended, i.e. 15 grains in 20 c.c. of water, and administered this solution at the rate of 1 c.c. per minute. The stage of narcosis sought was one just short of corneal anesthesia in which the patient lost orientation and often exhibited purposeless movements as though in delirium. "Lost" motor functions were first incited as defensive gestures, i.e. as a response to a painful stimulus. This was repeated several times, first supplementing, and later substituting for the stimulus a verbal command; by this time orientation, though nebulous, was partially restored. We found it expedient to continue repetitious performance of the function, against resistance, and in automatic cadence to counting. Meanwhile, picrotoxin was slowly introduced until appreciable analgesia was effected, a stage characterized by clarification of orientation and re-establishment of good contact. Though the patient might subsequently lapse into sleep, there was no amnesia for this period and restored motor functions were preserved. The stock solution of picrotoxin comes 3 milligrams to the c.c.; we diluted this to half-strength and administered it 1 c.c. per minute. We found that it generally required about 1 milligram of picrotoxin for each grain of sodium amytal previously administered to affect adequate analgesia. In our experience 12 grains of sodium amytal sufficed for the average adult male, varying generally, though not always, with size.

We can subscribe to the recognized principle that application of this "black magic" is not good treatment unless a coincidental psychodynamic readjustment takes place. This usually requires that the patient be carefully prepared for the procedure by explanation of the nature of the disability and the plan for treatment, and, that the "restoration" of function be followed by similar discussion, the aim being to neutralize aggressions projected from self-condemning guilt feelings which arise from the condition, the explanation, and the "cure". (Since the well-motivated individual is unable to differentiate between malingering and functional disability in his own symptoms, he may, wouthout real psychotherapy, become worse for the "cure".)

Functional overlay in physical disease, its incidence, its responsibility for loss of productive capacity and blighted happiness, and its prevalent iatrogenesis, demands the unrelenting effort of all physicians toward its prevention, or early recognition and cure. This cannot be accomplished as an afterthought, but must be integrated with all therapy, from the inception of medical care in every patient.

DISCUSSION OF: FUNCTIONAL OVERLAY IN PHYSICAL DISEASE

Discussed by: Reginald S. Lourie
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Captain Kerman is to be congratulated on the use he has made of his opportunity to be a psychiatric missionary, leading the organicists in military medicine to see their own part in creating the "gold-brick". He has made a sound mental hygiene approach toward orienting the orthopedist, and others in preventive measures and dynamic understanding, even handicapped as he was by the use of the so often misinterpreted term "functional" which emphasizes to them a body-mind dichotomy. The attitude of the organicists toward the psychiatrist is too often in any case, "Peel off the functional layers in the patient for me, and then I can cure him". However, if they can be brought to realize that a conversion symptom for example, involves the use of established pathways and physiological mechanisms in such a manner as to cause an individual to respond pathologically, its prevention becomes as real and necessary to them as procedures to avoid a contracture when a patient is in a cast. We could very well use a new term, in reaching common ground with the internist and surgeon, that would indicate a predominantly vegetatively determined reaction and avoid the too prevalent use of the diagnosis of psychoneurosis.

In at least one Naval Convalescent Hospital, by the use of a questionnaire which was given to each medical, surgical and orthopedic admission, the staff was brought to an awareness of the existence of potentially or actively disturbing psychogenic elements which could, or already had, prolonged recovery. Approximately 30% of all the questionnaires, and more than 50% of those answered by patients returning from overseas, indicated the existence of such elements. As anticipated, a majority of the staff members began to modify their concepts concerning, and handling of, these patients, and were encouraged in the handling of the so-called "functional overlay" by themselves.

Group therapy, using the ward atmosphere as a background, was found to be a valuable tool.

I agree heartily on the iatrogenic origin of many of the so-called functional manifestations but I disagree that the psychogenic factors involved are "relatively non-specific and superficial" or derived predominantly from "latent dependent cravings", as inferred by Dr. Kerman. Motivation, as a driving force in developing and perpetuating symptoms, has been discussed here today, but I should like to bring up fear and insecurity again as an example of the

specific and powerful driving factors in the development of "functional overlay". In screening Navy and Coast Guard personnel r turning from overseas, it appears that most of them are no longer afraid of dying, but they are still afraid. The majority of them are afraid of being crippled or manglod, much as described by Schilder in his concept of threat to body image. When such an individual is "violated" by a needle, a scalpel, or on orders for an instrument in every orifice, we, as physicians, are accomplishing something even the enemy was not able to achieve, and are threatening the body image. We are giving this patient the outlet for a socially acceptable expression of this type of fear by precipitating the development of symptoms. Here, it is the fear, and its attendant insecurity, not the symptom, that needs treatment.

A question comes to mind as to the rationale of the use of picrotoxin in association with intravenous amytal as a means of bringing thehysterical patient closer to consciousness so that he will be aware of the ability to use his paralyzed limb. One wonders whether a procedure such as sine wave stimulation on a completely conscious level wouldn't accomplish the same result. One wonders, too, whether the use of this procedure, as carried out, isn't merely tackling a symptom rather than the underlying cause.

It probably isn't too much to say that if there were more approaches to the total problem of selling preventive psychiatry, in the way that Dr. Kerman has handled it, the postulation that psychiatry is the future of medicine would come closer to the truth.

SHOCK TREATMENT (PSYCHOTICS)

Captain James S. Missett, MC
Captain Leo B. Porssion, MC
Captain, Samuel D. Lipton, MC*

In this paper we will attempt to evaluate the therapy we have employed in the treatment of closed ward psychotic patients at Vaughan General Hospital. First we would like to describe the type of patients we receive and the setup we employ for treatment. Vaughan General Hospital is the psychiatric center for the Sixth Service Command. As such it usually has over 300 neuropsychiatric patients. Of these 65 to 80 are closed ward patients. It is these closed ward psychotic patients who furnish the clinical material for this paper. The vast majority of them are from 19 to 35 years of age. Until recently the majority of them were evacuees from overseas theaters. There has been a small percentage admitted from camps in the United States. In this paper we have not divided the evacuees from the other smaller group. Occasionally, patients with severe anxiety or severe behavior problems are admitted to the closed ward. These non-psychotic states are not considered in this paper.

Our physical means of therapy do not essentially differ from many other setups but there are some accidental differences. Electroconvulsive therapy is used and the course of treatment varies from 10 to 12 convulsions. Insulin is employed in subshock doses. The insulin is given intravenously because it is believed that we have fewer delayed reactions. In subshock insulin, attempt is made to achieve a state of stupor, confusion and profuse diaphoresis without coma or convulsions. Patients are started on small doses which are increased until the desired reaction is obtained. In most cases it is necessary to give less than 100 units of insulin.

On initiating insulin treatment we start with a 5 unit test dose. Following that, the patient is given 10 units intramuscularly TID the first day, 15 units TID intramuscularly the next day and so on until 40 units intramuscularly are being given. The following day an intravenous dose of 40 units is administered at 8:00 a.m.and the patient is left in insulin subshock until 10 a.m. at which time breakfast is given. The intravenous doses are increased daily at about a rate of 10 units a day until 100 units of intravenous insulin is administered. In the majority of cases this will produce a good subshock reaction. In some cases it is not necessary to go as high as that. In estimating the degree of mental confusion, color charts are used. Patients are continued on intravenous insulin for a period of about six weeks.

In this paper the last 133 courses of treatment have been considered; these included 100 courses of insulin treatments and 33 courses of electroshock treatments. Evaluation has been made on the following basis. A complete recovery means that the patient has recovered his propsychotic personality. A social recovery means that the man is capable of making adjustment

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out in civilian life but shows some scars from his psychotic episode. Institutional recovery means the patient is capable of getting along in an institution either in an open ward or semiclosed ward. Slight improvements and no improvements at all are considered together as having no essential change.

Among the patients we receive, a large number show paranoid delusions as their outstanding psychotic symptom. Most of these present the clinical picture of paranoid schizophrenia. However, they were in a younger age group than the usual paranoid praecox and a good many of them should be listed as psychosis unclassified with paranoid delusions. Of the 50 patients, in this group who were treated with insulin, 20% showed a complete recovery, 40% a social recovery, 20% institutional improvement and 20% no essential change. In other words, 60% of these patients, after receiving insulin, were able to return to civilian life, and take care of themselves there without close supervision. On the other hand the paranoid cases did not do well when treated with electroshock. Of the 6 paranoid states treated with electroconvulsive therapy, none showed complete improvement or social improvement although 33% did show an institutional improvement.

There were 24 courses of treatment given to depressed patients. These were in the depressed phase of manic depressive psychosis, or involutional melancholias or severe reactive depressions. Eleven courses of insulin were given. The results of treatment with insulin were surprisingly poor. One patient out of 11 showed a complete recovery, the other 10 patients showed no change at all. On the other hand, a similar group of 13 patients with depression as their outstanding symptom, did very well with electroconvulsive therapy. 60% showed a complete recovery. An additional 8% showed a good social improvement. So that 68% of the patients were able to return to civilian life without requiring custodial care. This difference in the results of the treatment by insulin and electroshock of depressed patients is more striking when it is noted that 5 of the depressed patients who showed no change under insulin made a good clinical improvement when treated with electroshock.

Another contrast between insulin therapy and electroconvulsive therapy was found in a group of catatonic schizophrenics. Most patients with schizophrenia or schizophrenic-like psychosis appear to do well with subshock insulin treat-

ment. However, the catatonics seem to be an exception. Of the 11 patients treated with subshock insulin, only one made a social improvement and the rest showed no very marked change. That means that in this small group, less than 10% were able to return to civilian life without some degree of custodial care. In a similar, though smaller, group of catatonics who were given electric shock treatment, the results were satisfactory. 40% made a good social recovery and 30% showed institutional improvement. Again some of the failures with insulin were later treated with electroshock with good results.

We have not treated a large number of hypomanics, but in those that we did treat, the results were satisfying when subshock insulin was used. 50% of these patients showed either a complete recovery or social recovery. However with electroconvulsive therapy, our results were disappointing. Only 33% of the patients showed any degree of improvement and this was classed as an institutional improvement.

In a comparatively large group of patients who showed confusion, disorganization and symbolic thinking and who were classed as schizophrenics, or schizophrenic-like reactions, the results with both electric shock and subshock insulin were satisfactory. With either type of treatment, these patients improved, so that over 50% of them could be classified as either complete recoveries or social recoveries.

Patients showing fixed somatic delusions with anxiety did well with subshock insulin treatment. The series is small, but the four patients treated made either a good social recovery or complete recovery.

Recently we have been alternating insulin and electroshock so that a patient may receive insulin three days a week and electroshock three days. We have tried this in schizophrenics. We have not a sufficient number of patients treated with alternating insulin and electroshock to establish a third class comparison with insulin and electroshock alone.

Before instituting either electroshock treatment or insulin treatment, each patient is given psychometric tests and an electroencephalogram. These are repeated on completion of treatment. In this paper I have not attempted to evaluate those results.

Summary

(1) 133 courses of treatment were reviewed. Of these, 100 were with subshock insulin and 33 with electroconvulsive therapy.

(2) The cases were in soldiers in 19 to 35 years of age. Most of them had been evacuated from overseas although a small percentage were sent in from camps in the United States. With subshock insulin, the results were satisfactory in paranoid schizophrenics and in psychosis unclassified with paranoid ideas. Schizophrenics with disorganization and confusion did well with insulin. Treatment of hypomanics gave satisfactory results.

The results were unsatisfactory with insulin in the treatment of catatonic schizophrenics and of the depressed states including the depressed phase of manic depressive psychosis, involutional melancholias and reactive depression.

(3) In electroconvulsive therapy, good results were obtained in the treatment of schizophrenics with confusion and disorganization. Excellent results were obtained in the treatment of depressions. Fair results were obtained in the treatment of catatonic schizophrenics. Poor results were obtained in the treatment of hypomanics and paranoid states.

Conclusion

With paranoid states and hypomania insulin seems to be the preferred method of treatment. With depressed states and catatonic states, electroconvulsive therapy seems to be the preferred method of treatment.

SHOCK THERAPIES (PSYCHOTICS) and SHOCK THERAPY IN COMBAT SYNDROME

Discussion by L. J. Meduna, M. D., Associate Professor of Psychiatry, University of Illinois.

In order to evaluate both Captain Missett's and Captain Bloss' and their collaborator's papers properly, one has to fit the two articles into the broad pattern of the history of shock treatments. Insulin was first used in psychotic cases in 1929 by Miskolzy to prevent loss of weight and to promote appetite during the acute phase of the disease. In 1930, Edith Klemperer, a Swiss author, used insulin in subcoma doses for twelve hours a day in the treatment of delirium tremens and Korsakoff psychosis. A few years later, Sakel produced mild hypoglycemic conditions in the treatment of morphine addiction.

From these apparently modest attempts grew Sakel's powerful insulin shock treatment. The application of insulin shock treatment to anxiety states and to minor psychoses is apparently not very successful. So, reviving the original mild hypoglycemic insulin treatment is a basically sound attempt. The same method was used by Braunmuhl, in Germany, in so-called toxic or fatal catatonias with somewhat less satisfactory results. It is my own experience also that convulsive treatments and insulin shock treatments are less valuable in these conditions than they are in the treatment of major psychoses.

I believe it is highly significant of the modern trend in psychiatry that Captain Bloss did not try to classify his patients and to choose the classification as the basis of the treatment, but he selected rather a symptom group, that is, anxiety. With this symptom, we deal with a tangible condition and not such an elusive syndrome as the almost meaningless

diagnosis of schizophrenia.

As we know, the publication of convulsive treatment was about contemporaneous with that of the insulin treatment; but nevertheless, it took about three years before the two treatments were used in combination. The first report of combination of insulin and metrazol shock was published in 1937 by Georgi at the historical Munsingen meeting in Switzerland. He combined the metrazol and insulin treatment by inducing metrazol convulsions in the first hour of the insulin hypoglycemia. At the same time, I reported of a few cases of another form of combination which I called "crossed treatments"; that is, after a long series of insulin hypoglycemic shocks, I crossed over for a longer series of metrazol shocks, or vice versa. About six months later, Kuppers published his variety of combination which he called "alternative treatment"; that is, after every two days of insulin hypoglycemia, he switched to one day of metrazol convulsive treatment.

It is a pleasure to see, therefore, in Captain Missett's report that he used both the crossed treatment and alternating treatment, thus demonstrating that the psychiatric work in the Vaughan General Hospital is on a high scientific level. If I had any criticism of Captain Missett's procedure, it would be that I, personally, do not believe that to limit the number of electric shock treatments to ten or twelve, or to any number, is basically correct. I think that if the patient does not show any improvement about the tenth convulsive treatment, then the continuation of this treatment is pointless; however, if the patient shows improvement during the first ten to twelve convulsions, the treatment, I believe, should be continued as long as the patient shows any additional improvement. Furthermore, I still believe that it is good practice to elicit one or two convulsions after the apparent therapeutical optimum. I believe that Captain Missett's nomenclature is a sound policy inasmuch as he calls his insulin treatment "subcoma treatment"; but when the state is stupor, confusion and profuse diaphoresis, I think it might better be called coma-though not a deep one. The advantages of administration of insulin by means of intravenous injection are obvious. It cuts down the time of treatment considerably.

As far as Captain Missett's classification and his results go, it is surprising that he saw a 20 per cent complete recovery in patients classified as paranoid dementia praecox. I think we have to take this percentage with a grain of salt, all the more so in that the author himself seems to be in doubt about the classification. I believe that these are the patients who have been classified by Klási as acute paranoid hallucinosis and who most probably belong to the group of melancholia fantastica of Kraepelin.

As to the results in the other groups of treated psychotic patients, Captain Missett's results are in line with those in the literature.

THE USE OF SUB-COMA INSULIN IN THE TREATMENT OF SEVERE ANXIETY STATES

Capt. Charles L. Bloss, M.C. *
Capt. Edward T. Auer, M.C. *

Neuropsychiatric patients evacuated from overseas theaters to convalescent hospitals in the Zone of the Interior occasionally manifest a degree of anxiety, depressive, or conversion symptomatology incompatible with convalescent care. At Percy Jones Hospital Center special provisions were made at the General Hospital Annex for those few patients requiring more intensive supervision and treatment. As an integral part of this program a ward was provided for the administration of sub-coma insulin therapy to those patients manifesting a marked degree of anxiety.

Though Sakel in 1933 demonstrated that insulin could be successfully employed in diminishing unpleasant anxiety symptoms, the utilization of insulin in the treatment of basic anxiety reactions and the effectiveness of insulin in sub-coma doses received little attention until its extensive use by Debbelian, et al in treating psychiatric casualties from Dunkirk. Since that time Rawdon[2] of the New York Hospital has emphasized the dramatic relief of anxiety by sub-coma insulin in various kinds of excitement, and the method has been used extensively by the United States Medical Department in overseas theaters.[3]

Justification for the use of insulin has been based primarily on clinical observations, though many theoretical explanations have been advanced to explain the exact mechanism involved. As one [illegible] explanations, Bychowski[4] postulated a partial destruction of the pathologic ego. Berze[5] offered the opinion that the mechanism was a repetition of old psychiatric methods used to scare patients by making them fight for their existence. Hoss[6] saw in its use the appeal to the instinct of self-preservation through the fear of death, and Piers[7] saw in the treatment a guiltless fulfillment of immense oral cravings. From a physiological aspect, Himwich,[8,9,10] et al have noted increases in cholesterol and serum proteins and diminutions in phosphorous, potassium, amino acids, and glucose, but the significance of all these changes on the brain are not known. It is known, however, that cerebral function is definitely altered by hypoglycemia. The reason for the peculiar sensitivity of the brain to the lack of blood sugar lies in the fact that it is the only organ which obtains its energy from the combustion of carbohydrates alone. Though the liver, kidneys, or voluntary muscle may oxidize either fat or carbohydrate, the brain can resort to no alternative foodstuff. Once the available glucose is decreased, metabolism must decrease, and cerebral function suffers. This decrease in metabolism follows a definite pattern beginning with the higher cortical levels and proceeding down the phyletic scale. Thus, hypoglycemia as in electric or metrazol convulsive treatment includes the element of depression of brain metabolism. The exact relationship this has to the amelioration of the

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psychiatric illness is still unknown.[8] Gold,[11] by the use of mecholyl chloride, has attempted to measure the autonomic balance in patients treated with insulin shock and concludes that patients showing clinical improvement demonstrated an ability on the part of the autonomic nervous system to maintain its own balance. This coincides with our own clinical observations of stabilization of the autonomic nervous system in severe anxiety states.

In the selection of the sixty-five cases in our present series primary stress was placed on the presence of a marked degree of anxiety. Though weight loss was present in most cases, we did not adopt the attitude of Sands[12] that the treatment was of no value in the absence of clinical states producing loss of weight. The patients treated included a number of men with a prolonged history of neurotic traits as well as patients with previously stable personalities who became ill only after long periods of stress. Included are anxiety reactions occurring in combatant as well as non-combatant troops. In many cases a mixture of anxiety, hysterical, and reactive depressive symptoms were noted, but in all cases, the outstanding symptom was that of anxiety and fear.

METHOD

All patients treated had benefit of thorough psychiatric and psychometric examination, a complete physical and neurological examination, white blood cell count, hemoglobin determination, complete urinalysis, a Kahn serological test, and x-ray of the chest. In addition, general medical and surgical consultations as well as additional laboratory and x-ray studies were carried out when these measures seemed necessary.

The patient was started on 20 units of regular insulin, given intramuscularly at 0700 hours on the first day of treatment. The treatment was terminated at 1000 hours by the administration of glucose and orange juice in sufficient quantity to neutralize the insulin given. The dosage of the insulin was increased daily by increments of ten until the desired level of response was reached. This level was preferably somewhere between Stage I and Stage II as described by Himwich.[3] The course of treatment at this point was individualized, therapy being continued until, in the impression of the therapist, a desirable result had been obtained. The dosage of insulin was then decreased gradually until the original level was reached. Therapy was given on five days of each week, Monday through Friday inclusive, and where practical, the patients were encouraged to utilize pass privileges on week-end's. In the series an average maximum dosage of 71.6 units of insulin was utilized, the range extending from 50 to 140 units. The average duration of treatment was 19 days, with a range from 8 to 42 days. All treatments were given on a ward utilized for this purpose alone. Cases receiving higher doses, or those showing greater degrees of reaction were placed in available private rooms to avoid alarming the other patients should

untoward reactions occur. In this series three cases had convulsive seizures on one occasion during the course of their therapy. No complications or sequelae resulted. It was of interest that in each of these cases the convulsion occurred in the downward course of the treatment program and the patients admitted to excessive drinking the previous week-end. These cases were the only ones in which the treatment period had to be terminated by intravenous injection of 50% glucose. There were, however, a few cases in which the treatment period was shortened by early administration of oral glucose when the patient was experiencing moderately severe myoclonic twitching.

Precautions were taken to meet any emergency which might arise as a result of therapy. These were set forth in a list of instructions conveniently placed in the nurse's office on the ward. Nurses and other ward personnel were instructed in the nature of reactions and the care of such in patients on insulin therapy. Careful notes descriptive of each patient's reactions during therapy were recorded by the nurse in a book provided for this purpose. A medical officer was available on the ward at all times throughout the treatment period.

As previously stated, all cases treated had one common denominator, namely, the presence of anxiety symptomatology. However, a wide variety of psychopathology was represented in the group. The following cases have been selected for presentation to demonstrate some of the more common types seen:

CASE I

The patient was a 30-year-old white T/5 with 2-10/12 years of service who was admitted to the hospital on 8 June 1945. He had been an emotionally immature, unstable individual in civilian life who was strongly attached to his family. His work adjustment had been fair, but he had always been unable to operate under pressure or in competition with others. He went overseas in May 1944 and was in combat area four months in the ETO, during which time he "tagged along with the rest of the crowd", but never fired his rifle. He was wounded in his right leg in March 1945 and while being evacuated, was riding on a truck which ran over a mine, causing him to be thrown from the truck. Subsequent to this he developed a severe combat reaction for which he was evacuated to the Zone of the Interior. On arrival at this hospital he was confused, tense, emotionally labile, and demonstrated marked tremors and a startle pattern. At the completion of therapy he was relieved entirely of the anxiety features seen on admission. He gained only 3-1/2 pounds during the treatment. Psychometric retesting indicated he was performing at the same level as he had been at the time of his induction.

CASE II

The patient was a 26-year-old T/3 with 3-1/2 years of service at the time of his admission to the hospital on 23 April

1945. He was a college graduate with a degree in pharmacy whose preinduction history was essentially negative. In the service he served as an instructor in the technicians' school and later on as a technician with an evacuation hospital in a non-combatant area. He tried for a commission on numerous occasions, but failed each time. After each failure he became increasingly tense until he finally began to experience anorexia, nausea, vomiting, insomnia, marked tremors, diaphoresis, startle pattern, ideas of reference, and mild paranoid trends. These symptoms were predominant on admission. After treatment his anxiety symptoms subsided completely. A defeatist attitude present on admission no longer existed. He gained 6 pounds during treatment. Psychometric retesting indicated he was performing at the same level as he had at the time of his induction.

CASE III

The patient was a 29-year-old S/Sgt. with 4 years of service at the time of his admission to the hospital on 18 July 1945. His past history was essentially negative. In the service he functioned very effectively overseas in the Pacific theater with a supply unit. About two years before his hospitalization he began to experience anorexia, nausea, weight loss, and burning sensations in his abdomen. He continued at duty and returned to the Zone of the Interior on rotation. After a furlough he was assigned to the Personnel Section at the hospital. Here, his symptoms became aggravated and he complained as well of tenseness, tremors, diaphoresis, and reduction in potency. At the completion of his therapy he felt very much improved. He gained 15 pounds, his anxiety symptoms disappeared, and he was returned to duty status at his own request. Psychometric retesting indicated he was functioning at a level higher than he had at the time of his induction.

CASE IV

The patient was a 27-year-old white Pfc. with 3-6/12 years of service at the time of his admission to the hospital on 31 August 1945. His preinduction history was replete with neurotic stigmata in an inadequate, schizoid individual raised in a poor environment. After four months of service in the Army he was sent overseas where he participated in the North African, Tunisian, and Italian campaigns., during which time he was wounded on two occasions and returned to duty each time. He had a penile lesion in March 1944 for which he received antiluetic therapy. In January 1945 he began to worry about the possible effects that the luetic disease might have on him. He developed a severe syphilophobia with a concomitant severe chronic anxiety state which was subject to frequent acute panic states. Serologic tests for syphilis were all negative. On therapy his anxiety symptoms subsided entirely. His syphilophobia responded to intensive psychotherapy. He gained 6 pounds. Psychometric retesting indicated a moderate improvement in intellectual function.

RESULTS

From the observations made on the cases treated on this service we were impressed with the following as clinical evidence of therapeutic response to sub-coma doses of insulin in anxiety states:

(a) There was evidence of autonomic stabilization as was manifested by decrease in diaphoresis, disappearance of flushing, lowering of elevated blood pressure, slowing of the pulse rate, and a subsidence of multiple gastro-intestinal complaints, including anorexia, nausea, and vomiting.

(b) Tremors, startle patterns, insomnia, restlessness, and other evidences of increased psychomotor activity disappeared.

(c) Irritability and aggressiveness disappeared, and the establishment of rapport between the therapist and the patient was very much facilitated, rendering the concomitant psychotherapy much more effective.

(d) Patients entered more readily into the ward and occupational therapy program prescribed for them, and the ability of the patient to socialize while in the hospital and on pass progressively improved.

(e) There was an increase in appetite in almost every case. However, we were unable to correlate our clinical results with the rate or degree of weight gained, as had been previously described by other authors.[12] Some of our best responses were seen in patients in whom there was little weight gained, and in light of this we did not feel it advisable to terminate treatment should the patient fail to gain weight by the end of the first ten days. Although weight gain of as much as 15 pounds was observed, the average gain for the series was 4.26 pounds.

Objective efforts to correlate the degree of improvement with our appraisal of clinical response were undertaken in a small group of the total series who were given psychometric retests. The following trends were seen:

(a) An average gain in the full weighted score on the Bellevue-Wechsler examination of 16.2 points was observed, with a range of from 2 to 40.

(b) On the Shipley-Hartford Retreat examination there was an average gain of .1 points in the vocabulary score, with a range of -3 to +3, while on the abstraction score the average gain was 5.6 points with a range of 2 to 16. In no case was there a decrease in the abstraction score on the Shipley-Hartford Retreat examination.

After completion of the treatment program 22 of the 65

patients, or 34%, were considered recovered, 28 patients, or 43%, were considered much improved, and 15, or 23%, were considered as improved. In our opinion the 77% considered recovered or much improved were able to return to a general or limited duty status at the completion of hospitalization.

CONCLUSION

Sixty-five cases in which the outstanding pattern was that of severe anxiety were treated by means of sub-coma insulin. In evaluating the improvement noted in these patients we have duly considered the direct psychopathologic and physiologic effects of insulin therapy, but at the same time we have not overlooked the effect of the therapeutic enthusiasm of the staff, the morale on the ward, and the drama associated with the treatment program. Whereas most of the patients had been evacuated progressively with barbiturate sedation as the chief therapeutic approach, on the insulin ward a systematic program was instituted producing tangible results that the patient could observe both in himself and in others. Combined with active individual psychotherapy, sub-coma insulin therapy has proved a great value in the treatment of a variety of patients manifesting severe anxiety.

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GROUP PSYCHOTHERAPY IN AN ARMY HOSPITAL RELATING TO CIVILIAN READJUSTMENT

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T/4 Walter F. Sullivan

A group psychotherapy project was initiated at Vaughan General Hospital in October, 1944. The neuropsychiatric facilities of this hospital comprised a "center" for the more severe neurotics and psychotics. The bulk of the patients were men originally from Illinois, Wisconsin, and Michigan, who had broken down in overseas theatres. During the process of evacuation to the United States, there was a marked recession of acute reaction to war stress, either through definitive treatment or through spontaneous remission. Thus it was that even in this severe group of war reactions, a large number were sufficiently integrated to participate in group therapy.

The hospital facilities possessed superior educational, physical and occupational resources to meet the requirement of this type of patient. Trained enlisted psychiatric social workers as well as qualified psychologists familiar with Rorschach technique and Red Cross psychiatric social workers comprised part of the special features of the center. In addition, it was conveniently located a short distance from Chicago where transportation facilities enabled the patient to take frequent weekend and furlough trips to his home or for visits from the family.

At this hospital the individual patient was treated for an average period of three months. Because the patient had been previously carefully screened, the general therapeutic aim was to restore most of the individuals for civilian life rather than further military needs. In such an atmosphere, where patients were continually returning to civilian life, increased individual security was developed and associated with a diminution of hostility to the army and particularly to treatment within the military structure. An unusual opportunity was afforded the therapist to share, understand and help resolve the patient's first contact with family and community associations. Accordingly our group psychotherapeutic goals more nearly approximated civilian needs than most reports of therapy by military authors. Our goals were:

1. To diminish guilt feelings engendered by traumatic war situations.
2. To enhance self confidence as a result of group membership.
3. To assist the individual through his first steps of civilian adjustment on a group level.

It is felt that these superficial goals were accomplished in the group by:

1. Positive transference relationships to the group leader.
2. Group acceptance of the individual.
3. Partial and incomplete abreaction of emotions.
4. Individual repressions and suppression to obtain group acceptance.
5. Partial acceptance of emotional conflicts in their relationship to somatic expression.

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Thirteen groups, comprising about 250 patients were treated. Approximately 75% were neurotics, 15% psychotic reactions and 10% psychotics. Forty-five percent of the men's disorders were precipitated by combat, 35% occurred overseas, but not in combat, and 20% originated within the continental limits of the United States. While these figures are by no means accurate, it is to be noted that most of the patients were neurotics and had combat experience. In the group were both officers and enlisted men. It is noted that a number of psychotics attended, but none of these should be considered as such in the civilian sense of the word; they were all in a good clinical remission and had well-developed ego strength and probably would not develop a recurrence unless faced with strong external stress. The great majority of neurotics were by no means chronic and did not have well-established defense mechanism. It was our experience that the severe and chronic neurotics operating under the repetitive compulsive principle did not profit nor could contribute to other members of the group. The greatest number of men had either free floating anxiety or various psychosomatic complaints. They approached their dilemma from an organic base. They either did not have the background or the wish to appreciate the causative emotional factors. A number of men in each group gained partial insight and the desire to continue treatment in civilian life.

The following is an extract from written comments about the group by an intelligent, dependent, passive individual with severe anxiety who had not been particularly outstanding in the group:

> "These group discussions were a revelation (can't think of a stronger word) to me. I believed my stomach, bladder, etc., were actually on the bum...showed me that it was a mental condition. For the first time since hospitalization, I became aware of the nature of my sickness...my mind like my little toe, was something I just tolerated, not knowing its ramifications....it made me aware of something I never realized existed, namely: the motor that makes me tick. It's new to me, and I want to know more about it."

The staff initially was comprised of one psychiatrist, two enlisted social workers and a Red Cross recreational worker. The psychiatrist had previous experience with group psychotherapy of adults, under Dr. Paul Schilder and experience with children and adolescent groups in conjunction with S. R. Slavson. The staff, as a group, carefully selected members after review of the history and present behavior status of the individual. Special attention was paid to possibility for leadership and the ability to socialize. An attempt was made in each group to select a given number of leaders, a certain number of passive dependent individuals and a few individuals who were hostile and not amenable to the usual ward therapy. It was not found necessary to differentiate the men by virtue of combat experience. Officers were selected on the same basis, but with the provisions that there be more than one in the group. Diagnostic classification was not of major importance.

After several preliminary conferences, group meetings were scheduled and there were staff group conferences immediately following each session to evaluate the interplay amongst the group and to assay the role of the leader. Later, the social workers became group leaders and employed a psychologist and a Red Cross recreational worker as their team maintaining the same technique.

They had weekly conferences with the psychiatrist to further control their technique. The Red Cross workers, always women, had a passive role in early group sessions and later participated in skits taking various female roles. As the social workers progressed in their ability to lead groups, psychologists came in for training and participated. In this manner, an accumulative body of trained group personnel was developed. Meetings were held in a comfortable recreation room which included a semi-raised platform, which was at times used for impromptu situations under discussion. It was gradually learned that a circular seating arrangement eliminated the pre-conceived ideas of formal lectures. Smoking was permitted to ease the situation. It was found that a series of 12 to 15 consecutive daily sessions was of greater value than a longer time period with interval gaps. It was the considered policy that the group leader accept differences in opinions to his own statements or that of other members of the group and to offer these to the group for discussion. Near the end of each period, the group leader invariably paraphrased the main trend of thought and tried to keep continuity by referring to an unfinished discussion at the beginning of each session.

At the first meeting the group leader discussed the purpose of the group, namely: that it was felt all members wished an understanding of emotional problems and conflicts which had landed them in a psychiatric ward and understanding of the term "psychoneurosis" and what other people would think about them and problems of the future after their army career.

They were told that the hospital was a logical place for them to openly face their problems and that it was a practice ground for their future adjustment. It was stressed that all members had been particularly selected as those individuals who would profit from such a discussion. It was recognized that certain individuals would be more free than others. The men were told that if after three meetings, they did not wish to participate, they could discuss this with the group leader individually, and that then they would be free to leave the group. The group meetings would in no way comprise a part of their hospital record, and furthermore, participation would not delay or interfere with passes, furlough or separation. They were informed that army rank was to play no part and this was quickly evidenced in groups when staff members represented in themselves a tremendous disparity in rank.

Each staff member introduced himself, giving his name, home town, army experience, professional background and some personal information. Questions were encouraged from the group and frequently included "What is a social worker?"

In the next three sessions, the topics of individual development and background before military service, the presentation of anxiety and fear with physiological expression, the methods and mechanisms of controlling anxiety, the persistance of neurotic anxiety following their evacuation from overseas, and finally the difference between psychosis and psychoneurosis, was presented in as clear and understandable language as possible. This material was presented with the aid of the group's participation, and not in the formal manner outlined above. The film "Introduction to Combat Fatigue" and transcribed battle sounds were used to concretize discussion. It was found that the material was stimulating to the group and offered material to test the group leader and at the same time, to familiarize

themselves with other group members. Characteristic individual modes of behavior, such as intellectuality, masked hostility, withdrawal trends, guilt reactions and depressive tendencies, as well as individual acceptance, were noted.

At this stage, members were asked to relate their particular difficulties that led to hospitalization. This response varied with the individual, was filled with omissions and was open for discussion by other members. Severe emotional abreaction was never found in our groups. It is felt that group acceptance would not tolerate this on the one part, and that our patients through their previous series of hospitalizations, had bound up their free floating anxiety. Rather than a goal of abreaction by personal narration, our aim was to enable the group to see the similarity of anxiety reactions, the universality of psychosomatic complaints and the basic conflicts in all members. This served to clarify the common misconception in the army, "It's all in your head".

The following is a sample of a group introduction. Brief histories of the individuals are given to allow understanding of what transpired in the group:

W, a 24 year Jewish private, suffered an hysterical paralysis of his right leg in his first day of combat. He was reclassified, and he felt racially discriminated against in his new outfit, and was ashamed that he, a college graduate, never advanced beyond the grade of private. He was particularly conscious of the fact other men housed and fed Italian girls. He openly projected his feelings in an incident where he infuriated his mess sergeant by complaining about food and feeding it to a dog. There then ensued depression, resentment and excessive feelings of inferiority.

The patient was an only child of an over-protective mother. His father had a severe depression while the soldier was overseas. The patient had always been seclusive and had marked feelings of sexual inadequacy, and attempted to compensate in civilian life by studying sociology. One time while in college, he had a glove anaesthesia which cleared up by osteopathic treatments.

On the ward, the patient was a smug, self-satisfied individual with passive negativism. He was always attempting to take advantage of ward personnel because of his feelings of superior intellect. In addition, he projected his difficulty onto others and had no insight into his own disturbances. Group therapy helped this individual see his own role in provoking counter aggression. It did not give him insight into his fundamental problems.

S, is a 25 year staff sergeant of Hungarian-Jewish decent. He performed valuable service overseas in the Intelligence Division of Army Headquarters and underwent much enemy strafing. One evening, while standing on a plank platform of a house, he suddenly became tremulous and dizzy and fell two stories to the ground. Marked anxiety and tremor of the lower extremities developed and persisted. The patient was evacuated to the United States. He developed a recurrence of his initial symptoms while on furlough shortly before return to duty.

The patient was a severely traumatized individual who had seen severe hardships in the first war, as well as in Nazi-occupied Hungary. He was neurotically attached to a masochistic mother, who suffered continual physical abuse from a paranoid and borderline psychotic father. While overseas, and at the time of his fall, he had received news that his father was again maltreating his mother, and he worried excessively about this. The story of his family experiences had never been revealed in all his previous hospitalizations, and it was readily apparent to the patient that his marked tremulousness and excitability was a re-duplication of his emotional state during the many violent quarrels witnessed at home between his parents. His marked dependent feelings were neurotically sublimated by a fixed desire to placate the father by inordinate work and attention. His main desire for years was to keep his parents together and provide for the comfort of his mother.

On the ward, he initially showed marked anxiety which was heightened following a home visit. It soon became impossible for him to withhold his family concerns, and he gained a great relief in discussion with the ward officer. He later brought his mother to the hospital and she confirmed the distressing family situation and finally made plans to leave her husband and make her home with her son. This man had partially neurotically solved his present family difficulties by the time he started group psychotherapy and gained increasing ego satisfaction by positive leadership in the group.

G is a 26 year platoon sergeant who was hospitalized because of acute anxiety reactions and an exacerbated speech defect after severe combat for 57 days on Okinawa. While engaged in active combat, he received word that his brother had been killed in Europe. Shortly thereafter, his lieutenant and several men in his outfit were killed in front of him. Still later, while in combat, the hatch cover of his tank fell on his head and he developed acute anxiety reaction plus a severe speech disturbance following his return to safety.

The patient came from a very underprivileged family, and had numerous siblings. He was extremely close to his mother, who had told him that, he was the only one in the family who might accomplish something in life. He had repressed hostility towards his father, who was shiftless and at one time was placed on probation for incestual relationships with the patient's sister. His childhood speech defect was explained to him as caused by a fall on the stairs in which he struck his head. Following his mother's death, when he was 10, he was placed with a number of other siblings. One of these has been hospitalized for many years because of dementia praecox.

The patient blamed himself because he had influenced his dead brother to join the army, and had seen him before his death at a time when they both had a furlough. He was extremely conscientious, driving, and always trying to be the opposite of his shiftless, boasting father. He was always a very insecure and deprived individual who had done well in the army until the combined influence of prolonged combat, a blow on the head, loss of his brother and his own lieutenant, removed all ego support.

On the ward, he was a sensitive, dependent patient, who at first needed a great deal of support. The goal of therapy both individual and group was to enable him to again attain his compensation by group acceptance and self-confidence. His speech defect, as one might suspect, proved to be the most refractory of all his symptoms.

The following is their own account of their self introduction in a group meeting, with contributions from other members:

S stated, "I am 26, and I was born overseas and came to this country when I was 20. I am different from most of you fellows, because I know my trouble started before I was in combat. I got into the hospital, because during an air raid, I was on a roof and fell. I was unconscious, and when I came to, I was tremulous and tense. (He rationalizes his feelings of estrangement by his foreign birth. His family problems which he had already discussed with the ward officer, are omitted. Note also how the other patients pick up the basic omission). W asked "What was there that went on before, that caused you to be tense, if it wasn't the air raid?" S then told of having been in a concentration camp in Hungary and having no home land. His entire family had been placed there. He was finally freed and the major part of his youth from 1936 until 1940 was spent in supporting his parents and sister. "I intend to write a book concerning the relationships of men in a democracy". His basic desire was acceptance as an adult stemming from his original hostility toward his father. V said he could see why S said the causes of his difficulty preceded his combat experiences, but he didn't believe that combat would not also leave its effects. (This member was one who was exceedingly fearful of combat, had never seen any, and had projected all of his insecurities onto family tribulations during his absence). He thought S was as much afraid as anyone else. S said that he didn't feel that he was as much afraid as some of the others, who said they were. The members of the group refused to believe this.

W was next. "You will be here for the duration and six months before I get my story told". A group leader said 'Take all the time you want'. "I am an only child, and I usually have my own way. I went through college and received a B.S. degree, majoring in sociology. I had some nervous trouble when I was in school, but got over it. I got in the army like the rest of you and went into the Infantry. I was placed in the cadre as a Chaplain's assistant, and was sent to another camp in Florida. I got into an argument with the Chaplain and went overseas as a replacement to Italy. I went into the lines and then got shipped back on limited service. I was assigned to a railroad outfit and was sent on a detail away from the outfit. I got into a couple of arguments with the mess sergeant. He finally told me that he wouldn't feed me." (The manner in which this was stated was typical of the frustrated hostile child). "I called the Criminal Investigation Bureau on the telephone and told them that the mess fed civilians (Note the omission concerning the fact that it was Italian girls who were fed. The whole situation was reminiscent of a small child invoking additional strength to defend against expected retaliation by a father figure). "I was over heard by some of the fellows, and they beat me up. I was sent to the hospital, and after I got in, 'blew my top'". G asked if the people were hungry. He was answered evasively. M stated that people were fed

everywhere out of the army mess and W agreed that this was true.

Before anyone else made any comment, G said "I am going to tell my story. I was section sergeant in a tank outfit. Everything went OK until we got a new lieutenant on Okinawa. He didn't know anything about tanks. We were going down a road, when the second tank in line hit a mine. It blocked my tank, and I pulled back out of the line of fire. I signalled the lieutenant to halt, and I got out of my tank and went to see what the damage was. The assistant driver had been wounded rather badly in the back. I gave him first aid, and didn't let anyone touch him because I thought his back was broken. The other fellows had wanted to move him, but I had been told to leave it for the Medics. They were dropping mortar shells around us and the lieutenant couldn't back his tank back on the road. I went up and told him to pull over through a rice paddy, but he was afraid to do this. So I got in the tank and directed his tank out of there. The Medics finally got up there, but the officer didn't want them to go in because it was too dangerous. When they finally got in, the assistant driver was dead. I always wondered if I had done right. A few days later, I got hit on the head by the hatch cover. I couldn't stand on my feet, and I stuttered." (During this recital, the men were very interested, despite a marked intensification of the patient's speech defect. In this recital is seen the patient's extreme effort to compensate for feeling of loss engendered by the death of his old leader. This theme ran throughout his previous life in relationship to his parents. His typical ambivalence in 'I wondered whether I did right', is a constant problem of his present life situation. The actual traumatic incident of being struck by a hatch cover was definitely related to the onset of his speech difficulty at the age of 5, when he was told by his family that his speech difficulty followed a fall on his head.)

N asked if he had ever stuttered before. "Yes, when I was a kid, but I got over it". M said 'You had a tough job to make up your mind what to do there. You had to take care of those fellows who were not hurt.' (This member was exceedingly loyal and responsible, and was in the same combat area). S said 'You might have killed the wounded fellow trying to get him out. That is a job for the Medics'. S said "That is what they told me."

M was next. He looked at the floor with his hands tightly clasped and said, "I don't want to talk about myself. My problem can't be helped in the army". His group leader said 'That is your right. You can either talk or not, as you see fit'. (This individual throughout his hospital course was a stolid phlegmatic individual who showed no wish to accept aid for his own problems. He persisted in fixed somatic complaints).

Sometimes an individual who cannot relate in a group will be stimulated by the discussion to give an account to the ward doctor or some staff member in an individual interview.

R, a 35 year warrant officer, had been referred from the surgical service because of persistent rectal pain and itching. He had never been able to fully appreciate the affect of his combat experiences because he had spent most of his hospital time with excessive concern with his physical

symptoms. He had had three previous hemorroidectomies and had secured no relief, but had instead become sensitive to the fact that others had felt that he had "goldbricked". He forced himself to go with his outfit overseas and persisted through severe combat. He came into his ward officer's presence, without appointment, under great tension and related the following:

> "I have to tell you about my experiences overseas. I think that this might have something to do with my tenseness. I was with my enlisted men in a truck proceeding down a hillside road under enemy fire. We were mopping up around Brest. I could see a shell coming and gave the order to 'Stop and get out'. A few seconds later, a shell landed between the two front seats, destroying the vehicle". He told in another session of further combat experiences, and for the first time developed an understanding of how his somatic fixations were aggravated by stress.

An example of how group interaction influences one's attitude is portrayed in the following excerpt:

> W said that he always get started into an argument and always felt that the other fellow was at fault. V said openly that that was how W always seemed to act in the group, by being angry against the army and people. V said that he was fed up with the army too. W said "Yeah, but I always picked the guy that was the boss". G (a sergeant) said "That's the hell of a thing to do because that's the surest way to get into trouble." W said "I will more than likely have to get over that".

It is seen that W is accepting criticism within the group and is already free enough to recognize openly that he provokes aggression.

By the sixth meeting, groups had gained some understanding of their condition and generally brought up the point "Now that we know something about ourselves, what do others think of us and what can we tell them?" Members found that they had much in common when they returned home on pass or furlough. That long anticipated furlough was sometimes fraught with depression and anxiety. Many members found that what they had first discussed in groups actually was lived through when they left the hospital. Reaction to city noises was universal and sometimes provided situations of humor. The question "What can we tell others?" was brought up in a very modified spontaneous dramatic session with the job situation and family situation generally forming the background. For example: D, who had a difficult problem in discussing his reasons for discharge because his complaint was flat feet, depended on his sex appeal and his generosity. The leader suggested a scene in a bar. The Red Cross worker was a pickup.

(D) "Can I buy you a drink, honey?"
(Girl) "Sure".
They drink.
(Girl) "When did you get back, Mac?"
(D) "Just recently".
(Girl) "Out of the army?"
(D) "You bet".
(Girl) "How did you get out?"

(D) "Let's not talk about those small details. I'm flush, and have been looking forward to drinking and having as good looking a girl as you across the table from me. You know I spotted you when I came in and said to myself 'That's the one I have been dreaming of'. "How about another drink?"

Another patient, De, who had shame reactions returning to his home community from where eight comrades were never to be seen by their families, was markedly hostile and tense. He projected this onto civilians until he actually was able to go home and be accepted.

He said: "If an employer asked me too many questions, I would pop him in the nose."

The scene was the Personnel Manager's office in an iron mine. The social worker plays the part of a very strict personnel man who is wary of "neurotic war veterans". A knock is heard on the door. The office boy escorts De, seeking employment, into the office and introduces him to employment manager.

(Employment Manager) "So you're a veteran. My son is fighting in the Southwest Pacific. I haven't heard from him for a long time. Where did you serve?"
(De) "In the same area as your son."
(Employment Manager) "You look fine. What brought you back?"
De blocked and the skit had to end.

This was reenacted by other members and it was brought out by the leader that the civilian reactions were more natural than the soldier's. Later events proved this patient was the hero in his community and had the choice of five jobs.

The following is a group discussion about civilians:

R told about a fight he had with a civilian. The civilian had said "I hope that war won't end for another year". Other members said that they would kill the person who said that to them. The group leader threw out the statement "Is this true of the majority of civilians?" P responded that some fellows in the service were forgotten by their families. He told how his mother knocked down another woman who said she was getting more money than ever before because her sons were in the service.

Z told about a civilian who expressed the opinion that his son should develop an ailment whereby he could secure a discharge.

The group leader in a discussion like this brings out the common feeling of the group and at the same time always strives to present an understanding of the safe, secure, selfish civilian of which the very same soldier was once a member and to which he will again return after the war.

At the last group session, which was always announced well in advance, there was a general mood of ambivalence. The leader with little effort would invariably bring forth the reaction from the men that they would never again repeat their army experiences, but at the same time they were glad to

have been in the service. They compared experiences with their separate outfits and showed positive pride in their outfits. Most of them were intent on maintaining membership in Veterans' organizations.

Positive transference reactions to the leader and other members of the group continued throughout the patients' hospital stay. Patients always greeted the enlisted social worker affectionately with a pat on the back. They would comment as one did "You have more on the ball than some of the officers around here." They would mention their individual problems assuming the group leader knew all about them. Their closeness and familiarity with the Red Cross worker was maintained in an entirely different area of activity. Members of particular groups tended to continue friendships made within a given group.

CONCLUSION:

1. An account of group psychotherapy with 13 groups, totalling approximately 250 soldiers in a military neuropsychiatric center has been presented.

2. The group sessions were particularly oriented to readjustment of the soldier to civilian life. The environment offered unique opportunities to test transitional adjustments through family contacts and visits on the part of soldier and his family.

3. Selection of men for these groups rested principally on the basis of need for help and ability to socially participate. Most of the men had good backgrounds and broke only under severe stress. It was found that many psychotic reactions responded well to group therapy.

4. Long standing neuroses did not profit from group experience except on a most superficial basis.

5. It is felt that the primary psychological mechanisms operating within the group were:

   A. Positive transference and identification with the leader.
   B. Need for group acceptance.
   C. Repression of basic conflicts.
   D. Possibility of environmental change; ie, release from the army.

6. Definite sequential group trends were noted:

   A. Initial hostility and resistance to authority; ie, leader, hospital and army.
   B. General intellectual acceptance and understanding of emotional conflicts as related to their symptomatology.
   C. Guilt feelings about their condition associated with methods of social sublimation in family relationships, employment and civilian contacts.
   D. Fears of recurrence.
   E. Feelings of positive satisfaction regarding army experience, coupled with a gratified sense of survival from danger.

7. It is felt that these group psychotherapy experiences are particularly pertinent to adjustment difficulties of the war veteran in the future. The great majority of men should make a satisfactory civilian adjustment. Group psychotherapy on a military level has served to help concretize their problems and lessen their anticipatory anxieties.

DISCUSSION

Maxwell Gitelson, M.D.*

In discussing this paper I regret that I bring to the task important deficiencies: First I have never conducted any experiment in group psychotherapy myself. Second, I have had no Army experience on which to base my views of the particular work reported today by Captain Friend and his associates.

What I have to say is based upon some familiarity with the literature of the subject and upon impressions which the present report evoked. Besides this, in the course of previous efforts to comprehend what was going on in the treatment of patients in groups, I have of necessity had recourse to experience gained with spontaneous groupings which, during the course of work with individual patients, have shown themselves to have had a therapeutic effect.

I think that it can be stated from the beginning that individuals can and do spontaneously use group affiliation for self-integrating purposes and that in a measure such individuals are successful in these attempts at auto-therapy. Outstanding examples of this are to be found particularly among adolescents. These present us with the following types of spontaneous group formations which in the long run are of integrating value:

First, there is the adolescent gang, fully delinquent or operating just within the boundaries of tolerable behavior. Here, under the influence of a leader who carries the major burden of the guilt, and, by virtue of sharing the rest of the burden with companions, the individual lives out his emancipation conflicts. In some instances there is ultimate stabilization and socialization of the individual. I have in mind particularly the case of an ex-soldier whom I have recently treated, who joined a delinquent group during his teens, while in the midst of an emotional conflict involving his relationship to a kindly and admired but strict father. He was fortunate enough to escape the possible social consequences of this affiliation and in the upshot spontaneously gave up his delinquent associations and lived an integrated life as a worker and a married man for more than ten years. He cracked only after eight months of frontline service when his relationship to his superior recapitulated the old father conflict. It is interesting that his army reaction again took the form of group delinquency.

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Second, there are groups of intellectualizing adolescents, who in the course of their mutually inflicted pondering and philosophizing succeed in abreacting and resynthesyzing their several and separate conflicts.

Third, there is the group phenomenon of adolescent conversion which occurs even among normal individuals at these age levels. One sees attitudes of self-purification and self-dedication emerging and giving direction and stability to a previously shaky personality organization.

Fourth, we are all aware of the fact that the adolescent social group is a spontaneous self-educational experiment in which the adolescent learns the external limitations and possibilities of normal interpersonal relations. We are all familiar with the ebb and flow of activity and custom among teen-agers engaged in finding out where they fit in the scheme of things.

Finally, there are the individuals who spontaneously, often it seems by mere chance, change in the direction of more integrated living, after finding themselves in a different school, a different job, or in a different neighborhood. This does not mean that the new group affiliations are simply "better" in terms of our external and abstract evaluation of them. Quite the contrary may be true. The significant thing for the purpose of our discussion is that somehow these groups prove to be better for the given individual. They somehow complement him and his needs in some specific if obscure way. Somehow in the particular group he has found his integrative level.

All of this seems to sum itself up to the following propositions: The problems of group treatment belong among the problems of ego psychology. Neuroses and psychoses, as a part of their symptomatology, present us with the fact of the ego's failure to integrate the impulses of the individual with the externally imposed necessities of group living. In the given individual this shows up, often quite consciously, as a deep sense of difference, of loneliness, and of helplessness. What we seem to see in the therapeutic group is the creation of opportunities for mitigating these feelings with consequent liberation of the individuals capacities for interpersonal relations.

These opportunities may be enumerated as follows:

1. By way of the transference to a suitable leader personality the individual neurotic may gain an ally in his struggle against his excessively severe self-critical attitudes. The leader provides the patient with an auxiliary conscience which is more benign than his own.

2. In his association with other patients the individual may discover that there are others like himself who harbor omnipotent fantasies and destructive impulses. These are the chief barriers to the wish of every individual for positively-toned contact with his fellows. It might be immensely relieving to find oneself and others alive and well despite the prevalence of these fantasies and impulses. To discover that one is only human and not a pariah among men might be a really effective bit of reality testing.

3. A certain amount of abreaction through acting-out may be possible.

4. A certain amount of peripheral working through of specific individual conflicts may occur. I do not think that it would make much difference whether or not the individual were able actually to verbalize these specific conflicts. The empathy of the members of a therapeutic group with each other could enable each person in the group to sweat it out with each of the others in terms of his own specific conflicts. As in the case of young children who undergo psychotherapy, the development of intellectual or conscious insight is not a therapeutic necessity though it might occur as a byproduct.

5. It is known that in an equilibrated group the participating individuals assume certain balancing and complementary relationships which, in the individual case, means the gratification of particular needs and tendencies, with consequent relief of tensions.

6. Finally, the individuals in a therapeutic group, like those in a group of adolescents, may actually pass through a learning experience regarding the possibilities and limitations of interpersonal conduct and relationships.

In closing, it seems necessary to state that the present stage of group psychotherapy is one of empiricism based on borrowings from our scanty knowledge of the forces that have been identified as operating in spontaneous groups. To a great extent the prevalent ideas also stem from our more precise knowledge of the nature of limited interpersonal relations. This is inevitable. We can move only from the known towards the unknown. However, caution is necessary. There is still a great lack of precisely reported material and a greater lack of meticulous study of that material. Too many of the clinical reports in the literature seem to reveal psychotherapeutic intentions rather than an identifiable process or verifiable results.

The workers who participated in the experiment reported today are to be complimented on the fact that they have recognized the empirical nature of their work and have limited their intentions and their efforts to the practical requirement of doing everything possible towards easing the way of their patients into civilian life. The deductions which they have drawn from their work seem warranted in the present state of our knowledge.

GROUP PSYCHOTHERAPY FOR NEUROTICS

by Alexander H. Hirschfeld, Captain, M. C.*

The limits of the term psychotherapy are not well-established despite years of practice. Group psychotherapy is a phrase which is even more ephemeral and there is no agreement in the literature on its scope, constituent parts, or even the goals. A large number of neurotics at Percy Jones Convalescent Hospital offered an opportunity to clarify some aspects of the problem.

Before reporting our experiences, the limited nature of the clinical material must be emphasized. All of our patients were returnees from overseas theaters of war and the majority were combat casualties. Because of several circumstances, there is possibly a different prognosis in these cases from that of similar states observed in civilian practice. In the first place there was a favorable factor since a high percentage of these men had experienced minimal psychological difficulty previous to their breaks. Conversely a second factor augured for reduced success, all of the men standing to gain by extrication from an untenable military situation if they remained ill. A lifelong pension was also considered in the offing by most of the patients. Finally, these men were the most recalcitrant therapeutic risks of the neurotic group since 90% of the original number of such casualties had been screened out before reaching our hospital.

Our first step in attempting group therapy was the use of didactic presentations. In these lectures, both the content and the physician giving the material were varied. Unfortunately, when the men were quizzed on this material it was discovered that they had absorbed little or nothing. Since several workers in the armed forces have reported success with this method, our failure was difficult to explain unless one seldom-discussed factor is considered. In-service the physician pronounces his patient improved or well and the soldier returns to duty. Since the doctor, in this position, has command function, his success depends upon what the physician believes about the patient rather than on how the patient himself feels. Therefore, it is possible that reports based on the opinions of other therapists could vary widely with results determined by quizzing our patients, a procedure which may not have been utilized elsewhere.

The second procedure attempted was almost immediately appreciated as the method of choice. Discussion groups were inaugurated and in these, patients carried nearly all of the responsibility for picking material and guiding the course. The remainder of this paper is a description of our effort to make this procedure more useful.

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Paradoxically, the first significant variant in the success of these free discussion groups was discovered to be the physician. A statistical study of several hundred cases so treated confirmed this observation. Results varied more sharply with recognized capabilities of a therapist than they would with any other factor.

The influence of particular personalities over a group was again emphasized in an early mistake. In order to accelerate the program and to eliminate "red tape" the soldiers were interviewed both on admission and on return from initial furlough by the first physician available to them rather than by the man who would be their therapist. This procedure was almost destructive in its results because the group sessions thereupon deteriorated into get-acquainted procedures. The apparent conclusion was that it was necessary for the patients to know their therapist and for the therapist to know them at the onset of group treatment.

It will be seen that a wider concept of group psychotherapy was beginning to emerge from our early experience. Our work had begun with the frequently enunciated thesis that an hour or so of group discussion was, in itself, group psychotherapy. At least in the case of soldiers, who are neurotic, this was emphatically not the case. First, we discovered that the choice of therapists was very significant. Next, we discovered that previous contact between the therapist and his patients was important. Finally, it was appreciated that wider contact between physician and patient during treatment resulted in much better discussions, free though they were.

An example of the useful, broader contacts was ward rounds. This procedure was not originally scheduled as part of the convalescent hospital program in the army, but we found that sending our physicians through the barracks as frequently as possible was efficacious. It must be emphasized that this advantage was not appreciated in the ward rounds themselves, but in the group sessions which seemed to improve because of the ward rounds. This was especially true if the doctors were very careful with the normal amenities of physician-patient relationship, such as greeting each patient by name and briefly discussing some little problem of his illness.

A second type of additional contact which proved necessary was individual interviewing. This was indispensable, a vital contributing factor to the success of the discussion groups. It is fully described below.

As a result of our widening contacts in utilizing the other methods discovered, the phenomenon soon developed which was recognized as the essence of the method. This was group transference, and it seemed a different factor from individual transference. The

vital significance of being en rapport with a group can be appreciated after even a cursory examination of literature about this problem in the service. Without the use of some such method as this, the psychiatrist, an officer, is a symbol of hated authority. Furthermore, both he and the patient recognize that therapeutic success will re-precipitate the soldier into what, for him, is a horrible environment. As a result of these factors very few patients in service ordinarily seek out the type of psychiatric help they would in civilian life. On the other hand, when this point of group transference is reached in the present method, the physician suddenly emerges as the "kind father" and is capable of treatment which is truly efficacious. It is because of the development of this situation, in contrast to the ordinary military neuropsychiatric procedures, that the development of the group transference is regarded as the essence of this method.

At this point, the relation between the group and individual interviews defines itself. With the development of transference, certain men begin to want and even demand individual treatment. These men develop insight which is taken into the group and acts as a pump-priming factor in causing the entire group to precipitate significant psychodynamic material. Only a small portion of men require many real individual interviews under these circumstances, so that the amount of time consumed is negligible. The real treatment for the large majority proceeds entirely in the group discussion.

It can be deduced from these facts that the frequently-put question, "What is the best subject matter for discussion?" is superfluous. The patients have a large stock of appropriate material to discuss, and the problem is not how to have a doctor explain these problems to the men, but rather how the therapist can cause the group to precipitate them for discussion.

The size and the composition of the groups were the last questions to be settled. It was felt that a fairly large group, perhaps 40 men was entirely satisfactory in the early stages. Later, after the development of group transference, smaller groups were more efficacious and the division was made on a basis of symptomology. The symptom groups could number from 10 to 15 men.

It seemed best to completely eliminate men in two classifications. Deficients and borderline mentalities were not particularly harmful to the group, but were unable to extract enough gain to make the group sessions worth while to themselves. Aggressive psychopaths, on the other hand, were not difficult to handle, as is reported elsewhere. In fact, if the aggressive individual proved amenable to treatment he helped the group greatly. If he did not improve, but, on the other hand continued unreasonable antagonistic behavior he made a significant impression on the men around him. By comparison others

would shortly recognize how unreasonable or perverted some of their own attitudes were. The second particularly unfortunate group was the asocial psychopath. With his sneering resistance to the therapist and his ability to jeer at other patients who catharsed, he could silence the entire group in a short time. It was necessary to remove him.

In summary, it may be said that a pattern of group psychotherapy was worked out for convalescing neurotics. A preliminary period was required during which wide contacts with patients was necessary. As a result of the work done in this period, the phenomenon of group transference rather suddenly made its appearance. This factor of transference was the essence of the method. Following its development, patients were able to precipitate psychodynamic material in small groups. This reaction was abetted by individual interviewing and produced the usually-seen favorable results from psychotherapy. The goal of the method was seen to be the situation in which the group could meet and catharse in the presence of rather than under the direction of the therapist. This last situation was regarded as the goal of group psychotherapy because upon its achievement the patients demonstrated an ability to get well.

A sample case is appended: P, a corporal, arrived from Europe in a large group of patients. Tall, obviously intelligent, and forceful in speech, he had apparently become the spokesman for the group. His face had a tendency to flush and his wit had the effect of nearly causing a cheer from the group every time he aggressively addressed an officer. His antagonism was vicious but never exceeded the bounds of propriety.

On interview, this patient complained of difficulty in walking because of what he regarded as improperly tied off varicosities. The surgery had been done in service by men the patient regarded as incompetents. He had a marked tachycardia, felt he was caught in the mesh of the army hospital system, in which he was being transferred from one station to another by men who knew he was ill but who lacked the courage to discharge him. Neither did they have the ability to treat him, he felt.

The son of a dentist, he had a great deal of antagonism to a driving father. Because of the latter he had enrolled in dental school, had actually finished three years in this specialty before he revolted, argued with his father, and set out in commerce. He was very successful as a salesman, as much to spite his parent as for any other reason.

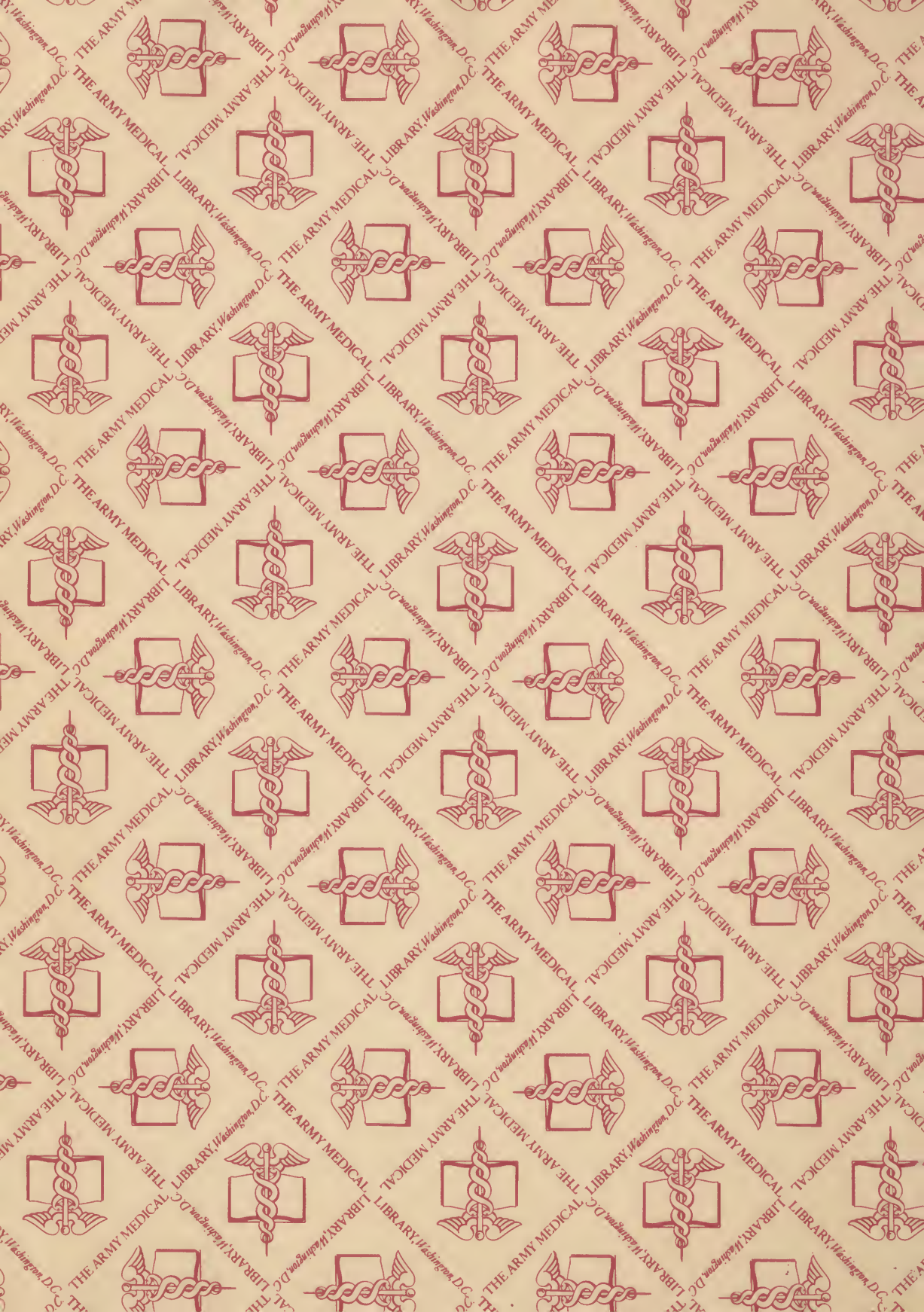
Then came the war and he was drafted. Placed in the infantry, he was singled out on routine inspection for the varicosities, about which he had determined not to complain. He was immediately hospital-

ized against his desire, and twice was operated on. Then he was placed on limited service, reclassified to non-combatant duty. His dental training was unearthed and despite protests made to every officer he could contact, including the commanding general of his station, he was classified as a dental technician. He immediately began quarreling with the dental officers to whom he was assigned, found it "impossible" to stand all day with his bad legs, was hospitalized for neurosis, and after about 4 months was evacuated from Europe to Percy Jones Hospital.

Since the soldier was very familiar with many medical concepts, he knew the doctors he had seen previously had been unsure in their own minds about how much of the pain came from the physical deformity and how much came from psychogenic overlay. In early group sessions, he would always put questions of this nature to the therapist, and demand informed answers. His antagonism was pointed, rather well-informed, and effective.

He was sent on a furlough where he quarreled with his father and with some of his friends. When he returned to the hospital he was a little less certain that he was not neurotic. Moreover, the group was developing transference and some of his colleagues were less willing to agree that all army doctors were ogres. He was treated with restraint and considerable care. Some of the other patients - this he later reported in interview - began telling him the individual interviews were helping them. Finally he requested one. Careful physical examinations were conducted by physicians about whose excellent qualifications he was previously told. He began "dropping in" on the therapist. Hostility to his father began to emerge. Therapy progressed.

Almost suddenly he began offering explanations of the illnesses of others in the group sessions. These soon developed into clearcut exposes of his own symptoms and their relationship to his father. He discussed marital problems next and brought out much psychosexual material. In six weeks, he showed very marked improvement and so did the group around him. With his "pump-priming" the other individuals had brought out similar material.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